

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

16267

STATE FILE NUMBER

FILED JUN 3 1957

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 588

Health, Welfare  
Public  
Service

300  
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Joseph</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>2002 S. 18th St.</b>		Length of stay in lb <b>life</b>	d. STREET ADDRESS (If outside, give location) <b>2002 S. 19th St.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Frances</b> <i>First</i> <b>Ann</b> <i>Middle</i> <b>Pritchett</b> <i>Last</i>			4. DATE OF DEATH <b>May 22, 1957</b> <i>Month Day Year</i>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 19, 1889</b>	9. AGE (In years last birthday) <b>67</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (City and state or country) <b>St. Joseph, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Lafayette Pearson</b>			14. MOTHER'S MAIDEN NAME <b>Elizabeth Thompson</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT Address <b>Margaret Rollett 2002 S. 18th S.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>general arteriosclerosis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>4200</b>					INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b> <b>uncertain</b>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <b>May 2/19 2:00 A</b> and last saw her alive on <b>May 22 1957</b> <b>May 21 57</b> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>J. P. Melaney, M.D.</b>			22b. ADDRESS <b>St. Joseph, Mo.</b>		22c. DATE SIGNED <b>5-24-57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>May 25, 1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Ridge Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>St. Joseph, Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Clark Funeral Home St. Joseph, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>May 31, 1957</b>		26. REGISTRAR'S SIGNATURE <b>Kathleen M. Allison</b>	

(Licensed Embalmer's Statement of Reverse Side)

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 DISTRICT OF COLUMBIA  
 OFFICE OF THE STATE EMBALMER  
 1300 K STREET, N.W.  
 WASHINGTON, D.C. 20004  
 TELEPHONE: 202-725-2000  
 FAX: 202-725-2001

APR 26 1961  
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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emb

by me, or by ..... Student Embalmer No. ....

working under my personal supervision.

Student .....  
 Signature of Student Embalmer

Signed *E. A. Clark*

Licensed Embalmer No. *42*

P. O. Address *St. Johns*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.

STARK EMBALMERS