

Health, Welfare Public Service

300 1-56

2

STANDARD CERTIFICATE OF DEATH

20185

STATE FILE NUMBER

FILED JUN 24 1957

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 663

1. PLACE OF DEATH a. COUNTY <i>Buchanan.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Jackson</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Joseph</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>Hannover City, Mo.</i> 3008 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>State Hospital No. 2</i>		Length of stay in lb <i>2 days, 7 mos, 6 days.</i>	d. STREET ADDRESS (If outside, give location) <i>6034 Hanwood.</i> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <i>NETTIE</i> Middle <i>E</i> Last <i>TOOHEY.</i>			4. DATE OF DEATH Month <i>6</i> Day <i>16</i> Year <i>1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-14-1880</i>	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife. AT HOME Home making</i>		9b. KIND OF BUSINESS OR INDUSTRY <i>None</i>		9c. AGE (In years last birthday) <i>76</i>
10a. BIRTHPLACE (City and state or country) <i>KANSAS CITY Missouri.</i>		10b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		

11. FATHER'S NAME <i>David Young Chalfante</i>		12. MOTHER'S MAIDEN NAME <i>Sarah Beadle</i>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No.</i>		14. SOCIAL SECURITY NO. <i>None.</i>	
15. INFORMANT <i>ONE Mrs. E. L. Simms - 6034 Hanwood, Hannover City, Mo.</i>		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i>		INTERVAL BETWEEN ONSET AND DEATH <i>10 minutes</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>Syphilis</i>	
	DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (n) <i>029X</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

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 <i>7:30</i> Month <i>June</i> Day <i>19</i> Year <i>1957</i> a. m. p. m.			20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	

21. I attended the deceased from <i>9-11-49</i> to <i>6-16-57</i> and last saw her ^{her} _{him} alive on <i>6-15-1957</i> Death occurred at <i>7:30 A. m</i> on the date stated above; and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE <i>C. E. Carrier.</i>		(Degree, or title) <i>M. D.</i>	22b. ADDRESS <i>State Hospital No. 2, St. Joseph, Missouri</i>	22c. DATE SIGNED <i>6-16-1957</i>

23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE <i>JUN 18 1957</i>	23c. NAME OF CEMETERY OR CREMATORY <i>UNION CEMETERY</i>	23d. LOCATION (City, town, or county) (State) <i>KANSAS CITY MISSOURI</i>
24. FUNERAL DIRECTOR <i>D.W. NEWCOMER'S SONS KANSAS CITY, MO.</i>		25. DATE RECD. BY LOCAL REG. <i>June 19, 1957</i>	26. REGISTRAR'S SIGNATURE <i>Mrs. Robert Fulton</i>

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
by me, or by, Student Embalmer No.
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Basil V. Howard*

Licensed Embalmer No. *46*
P. O. Address *R.C.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.