FILED AUG 5 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

23589
STATE FILE NUMBER

Registration District No. 42 Primary Registration District No. I000 Registrar's No. 828

1. PLACE OF DEATH
a. COUNTY: Buchanan
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): St. Joseph — Inside Limits: Yes ☒ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION: 23I8 S. 7th. St. — Length of stay in Ib: 7 months

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Buchanan
c. CITY OR TOWN: St. Joseph — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 23I8 S. 7th. St. — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Dug Middle: D. Last: Douglas

4. DATE OF DEATH: Month: July Day: 22, Year: I957

5. SEX: Male **6. COLOR OR RACE**: White **7.** MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: Sept. 25, I875 **9. AGE** (In years last birthday): 82 IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer **10b. KIND OF BUSINESS OR INDUSTRY**: Common **11. BIRTHPLACE** (City and state or country): Kansas City, Missouri **12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

13a. FATHER'S NAME: Unknown **13b. MOTHER'S MAIDEN NAME**: Unknown **14. NAME OF HUSBAND OR WIFE**: Mary Douglas (Divorced)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service) **16. SOCIAL SECURITY NO.**: 479-I8-7266 **17. INFORMANT**: Welfare Board Address: St. Joseph, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: I day
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Generalized arteriosclerosis — Ukn.
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 33/X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐ **20b. DESCRIBE HOW INJURY OCCURRED.** (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ **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 I-29-57, to 7-22-57 and last saw him alive on 7-20-57
Death occurred at I:I5 P.m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE S E Melvey M.D. (Degree or title) **22b. ADDRESS** Social Welfare Board I0th & Olive, St. Joseph, Mo. **22c. DATE SIGNED** 7-23-57

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial **23b. DATE**: July 24, I957 **23c. NAME OF CEMETERY OR CREMATORY**: City Cemetery **23d. LOCATION** (City, town, or county) (State): St. Joseph, Missouri

24. FUNERAL DIRECTOR: Clark Funeral Home **ADDRESS**: St. Joseph, Mo. **25. DATE RECD. BY LOCAL REG.**: July 29, I957 **26. REGISTRAR'S SIGNATURE**: Mrs. Robert Fulton

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 .....

Licensed Embalmer No. .....

P. O. Address .....

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