

FILED SEP 23 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

30891

STATE FILE NUMBER

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1007

300  
-57

Birth # 1552  
MEDICAL CERTIFICATION  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

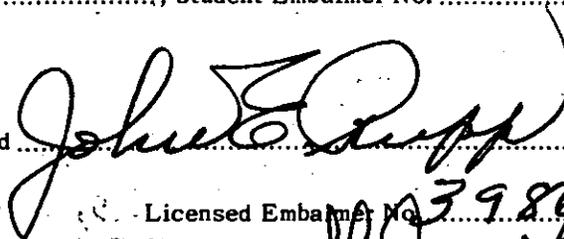
1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>Buchanan</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <u>St. Joseph</u> TOWN		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>St. Joseph,</u> 110
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mo. Methodist Hosp. 1day</u>		Length of stay in 1b	d. STREET ADDRESS <u>Rt #6,</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Ronald</u> Middle <u>Dean</u> Last <u>Gaddy</u>			4. DATE OF DEATH Month <u>Sept.</u> Day <u>6,</u> Year <u>1957</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 5, 1957</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	9. AGE (In years last birthday) <u>1</u> IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> IF UNDER 24 HRS. Hours <u>1</u> Min. <u>1</u>
11. BIRTHPLACE (City and state or country) <u>St. Joseph, Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Glendruce Gaddy</u>		13b. MOTHER'S MAIDEN NAME <u>Nadine Campbell</u>	14. NAME OF HUSBAND OR WIFE <u>none</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT <u>Glendruce Gaddy</u> Address <u>St. Joseph, Mo</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Primary Atelectasis</u> DUE TO (b) <u>Prematurity</u> DUE TO (c) <u>762, 5</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 <u>9</u> Month <u>6</u> , Day <u>5</u> , Year <u>1957</u> a.m. <u>AM</u> 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 <u>Sept 5, 1957</u> to <u>Sept 6, 1957</u> and last saw her alive on <u>Sept 6, 1957</u> Death occurred at <u>2 AM 9-6-57</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Sharon E. Wagoner M.D.</u> (Degree or title)		22b. ADDRESS <u>301 Illinois Ave St. Joseph, Missouri</u>	22c. DATE SIGNED <u>9-7-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9/7/57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Odd Fellows Public Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Joseph, Mo</u>
24. FUNERAL DIRECTOR <u>John P. Guff</u>	ADDRESS <u>St. Joseph, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>Sept 12, 1957</u>	26. REGISTRAR'S SIGNATURE <u>Mrs Robert Fulton</u>

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, ~~and~~ by ..... , Student Embalmer No. ....  
working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed



Licensed Embalmer No. 3986

P. O. Address Joseph

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.