

Health, Welfare, Public Service

FILED OCT 7 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER  
30902

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1044

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> all?
c. FULL NAME OF HOSPITAL OR INSTITUTION <b>503 Antoine St.</b>		Length of stay in lb <b>30 yrs</b>	d. STREET ADDRESS (If outside, give location) <b>503 Antoine St.</b>
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>HATTIE</b> Middle <b>(JONES)</b> Last <b>HATCH</b>			4. DATE OF DEATH Month <b>Sept.</b> Day <b>27</b> Year <b>1957</b>		
--	--	--	---	--	--

5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 24, 1900</b>	9. AGE (In years last birthday) <b>57</b>	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) <b>At Home</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (City and state or country) <b>Ethel Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>
---	--	---	--

13a. FATHER'S NAME <b>Benjamin White</b>	13b. MOTHER'S MAIDEN NAME <b>Emma Phillips</b>	14. NAME OF HUSBAND OR WIFE <b>Newton Hatch</b>
---	---	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>Not known</b>	17. INFORMANT <b>Mr. Newton Hatch</b>	Address <b>St. Joseph, Mo.</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>Intestinal Stasis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2-3 weeks</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Unknown - see Part II</b>	
	DUE TO (c) <b>578X</b>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Has had 13 abdominal operations and has had much sedation</b>		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 Month, Day, Year a.m. p.m.	
---	--

20d. INJURY OCCURRED WHILE AT <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>9-10-27-56</b> to <b>9/27/57</b> and last saw her <sup>her</sup> <sub>son</sub> alive on <b>9-27-57</b> Death occurred at <b>3:25 P</b> m on the date stated above; and to the best of my knowledge, from the causes stated.
---

22a. SIGNATURE (Degree or title) <b>Dr. W. E. Damer M.D.</b>	22b. ADDRESS <b>423 Main St. Joseph, Mo.</b>	22c. DATE SIGNED <b>9/28/57</b>
---	---	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>9-29-57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>New Cambria Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>New Cambria Missouri</b>
---	-----------------------------	---	--

24. FUNERAL DIRECTOR <b>Stamey Funeral Home</b>	ADDRESS <b>St. Joseph, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>Oct. 4, 1957</b>	26. REGISTRAR'S SIGNATURE <b>Mrs. Robert Fulton</b>
--	-----------------------------------	---	--

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

800 / -57

MAR 7 1958

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 *George P. Kerby*

Licensed Embalmer No. *1452*

P. O. Address *St. 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.