

FILED NOV 12 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34916

STATE FILE NUMBER

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1185

S. 300
v. 1-57

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Joseph</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>517 No. 24th St.,</u>		Length of stay in lb <u>Lifetime</u>	d. STREET ADDRESS <u>517 No. 24th St.,</u>
			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Arthur</u> Middle <u>P.</u> Last <u>Petri</u>			4. DATE OF DEATH <u>Nov. 1, 1957</u>		
			Month	Day	Year

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>75</u>	9. AGE (In years last birthday) <u>75</u>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self employed (Ret.)</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Bar & Recreation</u>	11. BIRTHPLACE (City and state or country) <u>St. Joseph, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Phillip Petri</u>	13b. MOTHER'S MAIDEN NAME <u>Caroline Gerngress</u>	14. NAME OF HUSBAND OR WIFE <u>-----</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT <u>Mrs. Chas. Bright, St. Joseph, Missouri</u>	Address
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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>Coronary Occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (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) <u>General Arthritis 10 yrs duration.</u>		19. WAS AUTOPSY PERFORMED? <u>2</u> 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.) <u>4201</u>
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20c. TIME OF INJURY Hour _____ 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 <u>St. Joseph</u>	COUNTY <u>Buchanan</u>	STATE <u>Missouri</u>
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21. I attended the deceased from Death occurred at <u>8:00</u> <u>P</u> on the date stated above; and to the best of my knowledge, from the causes stated.	and last saw him alive on <u>Nov. 1st 1957</u>
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22a. SIGNATURE <u>John G. Swails, M.D.</u>	(Degree or title)	22b. ADDRESS <u>Wathena, Kans.</u>	22c. DATE SIGNED <u>11-2-1957</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Nov. 4, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ashland Cemetery</u>	23d. LOCATION (City, town, or county) <u>St. Joseph, Missouri</u>	(State)
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24. FUNERAL DIRECTOR <u>Meierhoffer-Fleeman Inc. St. Joseph, Mo.</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>Nov. 6, 1957</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Robert Fulton</u>
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(Licensed Embalmer's Statement on Reverse Side)

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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DEC 3 1957

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 *W. H. Harrington*

Licensed Embalmer No. 3258 P. O. Address St. Joseph, Mo.

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.