

FILED JUN 30 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-021004

STATE FILE NUMBER 668

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

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> 0117		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Parkview Nursing Home</b>			Length of stay in 1b <b>4 yrs.</b>	d. STREET ADDRESS (If outside, give location) <b>Parkview Nursing Home</b>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>Lee</b> Last <b>Lockhart</b>				4. DATE OF DEATH Month <b>June</b> Day <b>22</b> Year <b>1958</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>February 24, 1874</b>		9. AGE (In years last birthday) <b>84</b>	10. FUNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife and Practical Nurse.</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Corder, Missouri.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>Erasmus Sisson</b>			13b. MOTHER'S MAIDEN NAME <b>Orville Roberts</b>		14. NAME OF HUSBAND OR WIFE <b>Albert M. Lockhart</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>none</b>	17. INFORMANT <b>Aubrey G. Lockhart</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>Coronary Occlusion</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4 1/2 hr</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Arteriosclerotic Heart Disease</b>						<b>unk</b>	
DUE TO (c) <b>4200</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Generalized Arteriosclerosis.</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>	
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 <b>11:05 A.</b> Month, Day, Year							
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>April 1956</b> to <b>June 22, 1958</b> last saw her alive on <b>June 20, 1958</b> Death occurred at <b>11:05 A.</b> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Martin H. Christ M.D.</b>				22b. ADDRESS <b>6106 King Hill Ave</b>		22c. DATE SIGNED <b>June 23, 1958</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE <b>June 25, 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>D.W. Newcomers Sons</b>		23d. LOCATION (City, town, or county) (State) <b>Kansas City, Missouri.</b>		
24. FUNERAL DIRECTOR <b>Meyerhoffer, Fleeman, Inc.</b>				25. DATE RECD. BY LOCAL REG. <b>June 25, 1958</b>		26. REGISTRAR'S SIGNATURE <b>Mrs. Clark Kudell</b>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Albert R. 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.