

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-028311
STATE FILE NUMBER

FILED SEP 15 1958 Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 959

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		c. CITY OR TOWN St. Joseph 0117	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2418 Bartlett		d. STREET ADDRESS 2418 Bartlett	
3. NAME OF DECEASED (Type or print) First Middle Last J. D. Prewitt		4. DATE OF DEATH Month Day Year Aug 29, 1958	
5. SEX male 0	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 30, 1886
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Roofing	11. BIRTHPLACE (City and state or country) Hiawatha Kansas
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unk	
13b. MOTHER'S MAIDEN NAME Unk		14. NAME OF HUSBAND OR WIFE Unk	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. unk	
17. INFORMANT John Baker, St. Joseph, Mo		Address	
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>20 MIN.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			4201
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 type="checkbox"/> NO <input checked="" type="checkbox"/> 2
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 Hiawatha		COUNTY STATE	
21. I attended the deceased from <u>UNATTENDED</u> , to _____ and last saw her alive on _____ Death occurred at <u>7:45 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>[Signature]</u> (Degree or title)		22b. ADDRESS <u>302 Farson St. Joseph.</u>	
22c. DATE SIGNED <u>9/19/58</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE <u>8/30/58</u>	
23c. NAME OF CEMETERY OR CREMATORY Hiawatha Kansas		23d. LOCATION (City, town, or county) (State) Hiawatha Kansas	
24. FUNERAL DIRECTOR <u>[Signature]</u>		25. DATE RECD. BY LOCAL REG. <u>Sept 11, 1958</u>	
ADDRESS St. Joseph, Mo		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

Dr. L. H. Piper

SA
MAR 22 1962

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, ~~only~~, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *John E. Rupp*

Licensed Embalmer No. *3986*
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.