

FILED SEP 29 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-031794

STATE FILE NUMBER

1005

Registration District No. 42

Primary Registration District No. 1000

Registrar's No.

S. 300
1-57

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buch.			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Joseph 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 518 N. 3rd		Length of stay in 1b 3Yrs.	d. STREET ADDRESS 518 N. 3rd. (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Victoria Clark			4. DATE OF DEATH Month Day Year Sept. 20 1958		
5. SEX F	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH August 15 1883	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elevator Operator		10b. KIND OF BUSINESS OR INDUSTRY Office Bldg.		11. BIRTHPLACE (City and state or country) Columbia, Missouri	
12. CITIZEN OF WHAT COUNTRY? U.S.		13a. FATHER'S NAME James Flynn		13b. MOTHER'S MAIDEN NAME Laura Woods	
14. NAME OF HUSBAND OR WIFE Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? no (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. PUBLIC INFORMATION		17. Informant Administrator St. Joseph, Mo.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage					INTERVAL BETWEEN ONSET AND DEATH Unk.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Generalized Arteriosclerosis					Unk.
DUE TO (c) 331X					
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"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 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 8/22/58 to 9/20/58 and last saw her alive on 9/21/58 Death occurred at 8:30 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) S. E. Meluney, M.D.			22b. ADDRESS 214 Herkpatrick Bldg. St. Joseph, Mo. DATE SIGNED Sept 23 1958		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Sept. 23 58		23c. NAME OF CEMETERY OR CREMATORY Ashland Cemetery St. Joseph, Missouri	
24. FUNERAL DIRECTOR Beatrice Gray 812 Pacific		ADDRESS		25. DATE RECD. BY LOCAL REG. Sept. 23, 1958	
26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell					

(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.

MEDICAL CERTIFICATION ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Dr. S. E. Meluney

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 *John T. Miles*

Licensed Embalmer No. *3146*

P. O. Address *Alhambra*

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.