

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-031862
STATE FILE NUMBER

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1053

FILED OCT 14 1958

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Buchanan</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>		c. CITY OR TOWN <u>St. Joseph</u> <u>0110</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>218 So 10th</u>		d. STREET ADDRESS <u>Rt #4</u> (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Length of stay in lb <u>51yr</u>			

3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>Saxton</u> Last <u>Saxton</u>			4. DATE OF DEATH Month <u>Sept</u> Day <u>30</u> Year <u>1958</u>		
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5. SEX <u>Female</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>May 20, 1899</u>	9. AGE (In years last birthday) <u>59</u>	FUNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (City and state or country) <u>Buchanan Co, Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Cyrus Saxton</u>	13b. MOTHER'S MAIDEN NAME <u>Anna Carr</u>	14. NAME OF HUSBAND OR WIFE <u>none</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>Esther Saxton</u> Address <u>St. Joseph, Mo</u>
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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>Mitral Insufficiency</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Unk.</u>
DUE TO (b) <u>Broken Compensation</u>		
DUE TO (c) <u>410X</u>		
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 <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.)
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20c. TIME OF INJURY Hour <u>11</u> Month <u>11</u> Day <u>13</u> Year <u>57</u> a.m. <u>11:15A.M.</u> 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 <u>St. Joseph, Mo</u>	COUNTY <u>Buchanan</u> STATE <u>Mo</u>
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21. I attended the deceased from <u>11/13/57</u> to <u>Sept 30, 1958</u> Death occurred at <u>11:15A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.		21b. Last saw her alive on <u>9/29/58</u>
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22a. SIGNATURE <u>St. Mearney M.D.</u> (Degree or title)	22b. ADDRESS <u>Social Welfare Board</u> <u>10th & Olive, St. Joseph, Mo.</u>	22c. DATE SIGNED <u>10/1/58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>10/2/58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ebenezer Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Joseph, Mo</u>
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24. FUNERAL DIRECTOR <u>John Hupp</u> ADDRESS <u>St. Joseph, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>Oct. 5, 1958</u>	26. REGISTRAR'S SIGNATURE <u>Mr. Clark Goodell</u>
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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
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Dr. S. F. 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 E. Rupp*

Licensed Embalmer No. *2986*

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.