

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-038942
STATE FILE NUMBER

1000

1226

Registration District No. 042 Primary Registration District No. Registrar's No.

FILED NOV 24 1958

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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 Buchanan		
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		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph's Hosp		Length of stay in lb 16 Yrs.	d. STREET (If outside, give location) ADDRESS 221 W. Nebraska		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Cleva Eskimo Delph			4. DATE OF DEATH Month Day Year Nov. 11 1958		
5. SEX Female-3	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 12-1913	9. AGE (In years (last birthday)) 45	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher		10b. KIND OF BUSINESS OR INDUSTRY Meat Packing	11. BIRTHPLACE (City and state or country) Lathrop, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Merritt Boggess		13b. MOTHER'S MAIDEN NAME Mary Emily Scott		14. NAME OF HUSBAND OR WIFE Adam B. Delph	
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. 496-24-3267		17. INFORMANT Address Adam B. Delph-221 W. Nebraska-City	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Accident Central Nervous System</i>					INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Hypertension</i>					<i>6 M</i>
DUE TO (c)					
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.) <i>331X</i>		
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 COUNTY STATE	
21. I attended the deceased from <i>31 Dec 1948</i> to <i>11 Nov 58</i> and last saw her alive on <i>Nov 11-1958</i> Death occurred at <i>12:15 P</i> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>Clara W. Slawson M.D.</i>			22b. ADDRESS <i>520 Francis St. St. Joseph, Mo.</i>		22c. DATE SIGNED <i>11-14-58</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Nov. 15-'58</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Ashland Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>St. Joseph, Mo.</i>
24. FUNERAL DIRECTOR <i>Wm. H. Alexander</i>			25. DATE RECD. BY LOCAL REG. <i>Nov. 14, 1958</i>		26. REGISTRAR'S SIGNATURE <i>Mr. Clark Goodell</i>

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION
 All diseases in Part I must be causally related.
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE.
 Dr. Owen W.D. Craig

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 *Wm. H. Alexander*

Licensed Embalmer No. *4450*

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.