

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-000295

STATE FILE NUMBER

126

FILED FEB 9 1959 Registration District No. 042 Primary Registration District No. 1000 Registrar's No.

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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) TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION D.O.A. Mo. Meth. Hosp.			Length of stay in 1b 37 years		d. STREET ADDRESS (If outside, give location) 2007 S. 10th St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First MIDDLE LAST GEORGE C. HOUSEWORTH				4. DATE OF DEATH Month Day Year Jan. 24, 1959					
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 July 12, 1894		9. AGE (In years last birthday) FINDER YEAR IF UNDER 24 HRS. 64 Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) railroad man			10b. KIND OF BUSINESS OR INDUSTRY Railroad Co.		11. BIRTHPLACE (City and state or country) Duluth, Minnesota		12. CITIZEN OF WHAT COUNTRY? USA		
13a. FATHER'S NAME Clarence Houseworth			13b. MOTHER'S MAIDEN NAME McBride			14. NAME OF HUSBAND OR WIFE Ruth			
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. 500-07-8455		17. INFORMANT Address Mrs. Ruth Houseworth, 2007 S. 10th St. Joseph				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion							INTERVAL BETWEEN ONSET AND DEATH 5 Min.		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ 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 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.) 4201						
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 _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Typed name of Health Officer) Assistant City Health Officer						22b. ADDRESS Bol From		22c. DATE SIGNED 2-5-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 1/27/1959	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery			23d. LOCATION (City, town, or county) (State) St. Joseph Mo.			
24. FUNERAL DIRECTOR Hester-Bosman			ADDRESS St. Joseph, Mo.		25. DATE RECD. BY LOCAL REG. Feb. 6, 1959		26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell		

MEDICAL CERTIFICATION USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Dr. L. H. Pifer

8701 87834

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 *[Handwritten Signature]*
Licensed Embalmer No. *1848*
P. O. Address *K. C. ...*

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.