

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-000307

STATE FILE NUMBER

FILED JAN 26 1959

Registration District No.

042

Primary Registration District No.

1000

Registrar's No.

78

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>St. Joseph</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Joseph</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Mo. Meth. Hospital</b>		Length of stay in lb <b>44 yrs.</b>	d. STREET ADDRESS (If outside, give location) <b>1706 Prospect Ave.,</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>MATTIE</b> Middle <b>ALICE</b> Last <b>LAYSON</b>			4. DATE OF DEATH Month <b>January</b> Day <b>20</b> Year <b>1959</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 1, 1888</b>	9. AGE (In years last birthday) <b>70 yrs.</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (City and state or country) <b>Platte City, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>J. W. Eskridge</b>		13b. MOTHER'S MAIDEN NAME <b>Elizabeth Purdee</b>		14. NAME OF HUSBAND OR WIFE <b>John F. Layson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes <input type="checkbox"/> NO <input checked="" type="checkbox"/> or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Mr. John F. Layson, St. Joseph, Mo.</b> Address <b>1706 Prospect Ave.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gastrointestinal Hemorrhage</b>					INTERVAL BETWEEN ONSET AND DEATH <b>1 Day</b>
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 <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 _____ 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 <b>inattended</b> to _____ and last saw her/him alive on _____ Death occurred at <b>4:10 A.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>St. Joseph, Mo. Health Officer</b>			22b. ADDRESS <b>St. Joseph</b>		22c. DATE SIGNED <b>1-22-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Jan. 23, 1959</b>	23c. NAME OF CEMETERY OR CREMATOR <b>Ashland Cemetery</b>		23d. LOCATION (City, town, or country) (State) <b>St. Joseph, Missouri</b>	
24. FUNERAL DIRECTOR <b>Stoney Funeral Home (GAS)</b>			ADDRESS <b>St. Joseph, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>Jan 22, 1959</b>	26. REGISTRAR'S SIGNATURE <b>Mrs. Clark Goodell</b>

MEDICAL CERTIFICATION  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diagnoses in Part I must be causally related.

Dr. L.H. Piper

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 *Charles E. Bennett* .....

Licensed Embalmer No. *4677* .....

P. O. Address *St Joseph 1720* .....

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.