

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-000335  
STATE FILE NUMBER

FILED JAN 12 1959 Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 7

300  
1-57

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) OR TOWN <b>St. Joseph</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Joseph</b> 117
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Mo. Meth. Hospital</b>		Length of stay in lb <b>60 Years</b>	d. STREET ADDRESS <b>709 Shady Ave.,</b>
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <b>LOIS ELLA RICKETTS</b>			4. DATE OF DEATH <b>January, 3, 1959</b> Month Day Year		
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March, 13, 1877</b>	9. AGE (In years last birthday) <b>81 years</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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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>Quitman, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
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13a. FATHER'S NAME <b>Andrew Bucklu</b>	13b. MOTHER'S MAIDEN NAME <b>Nancy Elizabeth Charter</b>	14. NAME OF HUSBAND <del>GRACE</del> <b>William E. Ricketts, Deceased</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) <b>No.</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Miss Marie Ricketts, St. Joseph, Missouri</b> Address <b>709 Shady Ave.,</b>
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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) <b><i>Chronic Bronchitis</i></b>		INTERVAL BETWEEN ONSET AND DEATH <b><i>10 days</i></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) <b>491</b>		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 Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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
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21. I attended the deceased from <b>Dec 26 - 1958</b> to <b>Jan 3 - 1959</b> and last saw her <sup>her</sup> alive on <b>Jan 3 - 1959</b> Death occurred at <b>6:45 A. m</b> on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <b><i>Orval W. Henry MD</i></b> (Degree or title)	22b. ADDRESS <b><i>526 Francis St St Joseph Mo</i></b>	22c. DATE SIGNED <b><i>1-5-59</i></b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Jan. 5, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ashland Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Joseph, Missouri</b>
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24. FUNERAL DIRECTOR <b>Stoney Funeral Home</b> <b>-F.A.S.</b>	ADDRESS <b>St. Joseph, Mo.,</b>	25. DATE RECD. BY LOCAL REG. <b>Jan. 5, 1959</b>	26. REGISTRAR'S SIGNATURE <b><i>Mrs. Clara Goodell</i></b>
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(Licensed Embalmer - Statement on Reverse Side)

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

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 Mo .....

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.