

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

9-000356
STATE FILE NUMBER

Health,
Welfare
Public
Service

300
-57

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 131

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Buchanan</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Ray</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <u>Richmond</u> 08910 |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hosp. #2</u> | | Length of stay in 1b <u>10mo. 28days</u> | d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |

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|--|----------------------------------|--|---|--|---|
| 3. NAME OF DECEASED (Type or print) First <u>Nannie</u> Middle <u>X</u> Last <u>Tarr</u> | | | 4. DATE OF DEATH Month <u>Feb.</u> Day <u>1</u> Year <u>1959</u> | | |
| 5. SEX <u>female</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2. DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>March 4, 1875</u> | 9. AGE (In years last birthday) <u>83</u> | IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> |
| 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 | 11. BIRTHPLACE (City and state or country) <u>Pettis County, Mo.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |

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|--|--|---|--|--|--|
| 13a. FATHER'S NAME <u>unknown</u> | | 13b. MOTHER'S MAIDEN NAME <u>unknown</u> | | 14. NAME OF HUSBAND OR WIFE <u>unknown</u> | |
| 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>unknown</u> | | 17. INFORMANT Address <u>State Hosp. #2 Records, 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>cardiac insufficiency, broncho pneumonia</u> | | | INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) <u>arteriosclerotic heart disease, Senility</u> | | |
| | DUE TO (c) _____ | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4280</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2 |

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|---|--|--|--|---|--|
| 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 _____ 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 March 1958 to Jan. 1959 and last saw her alive on Jan. 31, 1959
Death occurred at 6:30a. m on the date stated above; and to the best of my knowledge, from the causes stated.

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|--|--|--|--|-------------------------------------|
| 22a. SIGNATURE (Degree or title) <u>M. Mohammed Tahiri M.D.</u> | | 22b. ADDRESS <u>State Hosp. #2, St. Joseph, Mo.</u> | | 22c. DATE SIGNED <u>2/1/1959</u> |
|--|--|--|--|-------------------------------------|

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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 23b. DATE <u>2/1/1959</u> | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City, town, or county) (State) <u>Richmond Mo.</u> |
|---|------------------------------|------------------------------------|--|

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| 24. FUNERAL DIRECTOR <u>Heaton-Bowman</u> | ADDRESS <u>St. Joseph, Mo.</u> | 25. DATE RECD. BY LOCAL REG. <u>Feb 5 1959</u> | 26. REGISTRAR'S SIGNATURE <u>Wm. Clark Goodell</u> |
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Dr. Mohammed Tahiri
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
 MEDICAL CERTIFICATION
 All diseases in Part I must be causally related.

No payment

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 V. Hendricks*
Licensed Embalmer No. *4848*
P. O. Address *K. C. 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.**