Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-004548
STATE FILE NUMBER

FILED FEB 16 1959

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 162

1. PLACE OF DEATH
a. COUNTY Buchanan
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) St. Joseph — Inside Limits Yes ☑ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Sunny Slope Nursing Home, 3225 So. 11th St — Length of stay in 1b 22 yrs

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Buchanan
c. CITY OR TOWN St. Joseph — Inside Limits Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location) 811-1/2 No. 5th St. — Reside on Farm Yes ☐ No ☑

3. NAME OF DECEASED (Type or print) First JENNIE Middle EVELYN Last CLAY

4. DATE OF DEATH Month Feb. Day 10 Year 1959

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH Feb. 12, 1885
9. AGE (In years last birthday) 73 — 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) At Home
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (City and state or country) Mt. Sterling Illinois
12. CITIZEN OF WHAT COUNTRY? U S A

13a. FATHER'S NAME Joseph Alexander
13b. MOTHER'S MAIDEN NAME Sophia Smith
14. NAME OF HUSBAND OR WIFE Thomas W. Clay (Deceased)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Mr. Charles Houston Address 305 Clayton St. St. Joseph, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH Unk.
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) 331X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 2/9/59, to 2/10/59 and last saw her alive on 2/9/59
Death occurred at 12:55A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Collis Roundy MD
22b. ADDRESS Social Welfare Board 10th & Olive, St. Joseph, Mo.
22c. DATE SIGNED 2/11/59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 2-12-59
23c. NAME OF CEMETERY OR CREMATORY Ashland Cemetery
23d. LOCATION (City, town, or county) St. Joseph (State) Missouri

24. FUNERAL DIRECTOR Stamey Funeral Home NHS. ADDRESS St. Joseph, Mo
25. DATE RECD. BY LOCAL REG. Feb. 12, 1959
26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.
Dr. Collis Roundy
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.