

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-004572

STATE FILE NUMBER

FILED MAR 2 1959 Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 207

300  
1-57

2

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>Harrison</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>New Hampton</b> <b>c 41 b 0</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>State Hospital #2</b>		Length of stay in 1b <b>10 years</b>	d. STREET ADDRESS <b>7 mi. south of town</b>
			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First	Middle	Last	Month	Day	Year
<b>WALTER FRANCIS</b>			<b>Feb. 18, 1959</b>		

5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 3 DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 5, 1871</b>	9. AGE (In years last birthday) <b>87</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
-----------------------	----------------------------------	---	---	--	---	--------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>carpenter</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
---	-----------------------------------	---	---

13a. FATHER'S NAME <b>Samuel Francis</b>	13b. MOTHER'S MAIDEN NAME <b>Amanda Holms</b>	14. NAME OF HUSBAND OR WIFE
---	--	-----------------------------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unk.</b>	16. SOCIAL SECURITY NO. <b>unknown</b>	17. INFORMANT <b>Records, State Hospital #2, St. Joseph</b>	Address <b>Mo.</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>Arteriosclerotic Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>16 years</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Arteriosclerosis, general</b>	<b>15 years</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.) <b>4260</b>
---	---

20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
--	--	------------------------------	--------	-------

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 Death occurred at <b>3:30 P.M.</b>	to <b>February 18, 1959</b>	and how long he was alive on <b>February 18, 1959</b>
--	-----------------------------	---

22a. SIGNATURE <b>Mohammad Tahir M.D.</b>	(Degree or title)	22b. ADDRESS <b>State Hospital #2, St. Joseph</b>	22c. DATE SIGNED <b>2/18/59</b>
--	-------------------	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>2/18/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Matkins Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>New Hampton (rural) Missouri</b>
---	-----------------------------	---	--

24. FUNERAL DIRECTOR <b>MS Haas</b>	ADDRESS <b>Bethany, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>Feb. 27, 1959</b>	26. REGISTRAR'S SIGNATURE <b>Mrs. Clark Handell</b>
--	--------------------------------	--	--

Dr. Mohammed Tahir  
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
 MEDICAL CERTIFICATION  
 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 *M. Haas* .....

Licensed Embalmer No. *3899* .....

P. O. Address *Bethany, 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.