

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-004581

STATE FILE NUMBER 252

FILED MAR 16 1959

Registration District No. 042

Primary Registration District No. 1000

Registrar's No. 252

300
1-57

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Joseph <i>c 117</i> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph's Hospital		Length of stay in 1b 50 Yrs	d. STREET ADDRESS (If outside, give location) 1224 South 6th Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First JULIAN Middle JUSTIN Last HECTORNE			4. DATE OF DEATH Month March Day 8, Year 1959		
---	--	--	--	--	--

5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 21, 1890	9. AGE (In years last birthday) 68	10. UNDER 1 YEAR Months Days	11. UNDER 24 HRS. Hours Min.
----------------	---------------------------	---	-----------------------------------	---------------------------------------	---------------------------------	---------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. (10) Buyer		10b. KIND OF BUSINESS OR INDUSTRY Swift & Co.	11. BIRTHPLACE (City and state or country) St. Augustine, Ill. 1	12. CITIZEN OF WHAT COUNTRY? USA
--	--	--	---	-------------------------------------

13a. FATHER'S NAME Justin F. Hectorne	13b. MOTHER'S MAIDEN NAME Mary McNierney	14. NAME OF HUSBAND OR WIFE None
--	---	-------------------------------------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give name and dates of service) Yes W.W.# 1	16. SOCIAL SECURITY NO. 493-18-1436	17. INFORMANT Frank Hectorne Address Cameron, Mo.
--	--	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <i>arteriosclerosis</i> DUE TO (c) <i>cirrhosis of liver</i>		INTERVAL BETWEEN ONSET AND DEATH <i>not last</i> <i>under</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>4201</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2

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.) <i>4201</i>
---	---

20c. TIME OF INJURY Hour Month, Day, Year 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 <i>2-26-59</i> to <i>3-8-59</i> and last saw her alive on <i>3-8-59</i> Death occurred at <i>10:43 P</i> m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Deed or title) <i>Clement G. Dupont M.D.</i>	22b. ADDRESS <i>St. Joseph</i>	22c. DATE SIGNED <i>3-10-59</i>
---	-----------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>Mar. 11, 59</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet Cemetery</i>	23d. LOCATION (City, town, or country) (State) <i>St. Joseph, Mo.</i>
--	---------------------------------	--	--

24. FUNERAL DIRECTOR <i>H.O. Sidenfaden & Son</i>	ADDRESS <i>St. Joseph, Mo.</i>	25. DATE RECD. BY LOCAL REG. <i>Mar. 10, 1959</i>	26. REGISTRAR'S SIGNATURE <i>John Clark Handell</i>
--	-----------------------------------	--	--

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.
 Dr. Clement G. Dupont
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
 MEDICAL CERTIFICATION

AUG 24 1959

MAR 15 1959

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 *Robert H. Yaple*

Licensed Embalmer No. 3309

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.