

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-008454

STATE FILE NUMBER

FILED MAR 30 1959

Registration District No. 042

Primary Registration District No. 1000

Registrar's No. 300

300  
-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 6117 0		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Crestview Village		Length of stay in lb 58 yrs.	d. STREET ADDRESS (If outside, give location) Crestview Village 11-B		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Ruth Sacket Cherrington			4. DATE OF DEATH Month Day Year March 22, 1959		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 8, 1876	9. AGE (In years last birthday) 82	FUNDER YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (City and state or country) Kahoka, Missouri		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Samuel Sacket		13b. MOTHER'S MAIDEN NAME Josephine Barnett		14. NAME OF HUSBAND OR WIFE Ezra M. Cherrington	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	17. INFORMANT Address Miss Ann L. Cherrington, St. Joseph, 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>Arteriosclerotic heart disease, secondary</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <i>Renalized arteriosclerosis</i> DUE TO (c) <i>unknown</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4200					INTERVAL BETWEEN ONSET AND DEATH <i>5 plus years</i> <i>unknown</i>
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.) 4200		
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
21. I attended the deceased from <i>April 23, 1954</i> to <i>March 22, 1959</i> and last saw her <sup>her</sup> alive on <i>3-18-59</i> Death occurred at <i>7:00</i> A. m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>William H. Ames, MD</i> (Degree or title)			22b. ADDRESS <i>902 Edmond St</i>		22c. DATE SIGNED <i>3-23-59</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>	23b. DATE <i>Mar. 24, 1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Memorial Park Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>St. Joseph, Missouri</i>	
24. FUNERAL DIRECTOR <i>Mrs. Schaffer-Flanagan Inc</i> <i>67 S.W.</i>		ADDRESS <i>St. Joseph, Mo.</i>	25. DATE RECD. BY LOCAL REG. <i>Mar. 24, 1959</i>	26. REGISTRAR'S SIGNATURE <i>Mrs. Clark Sandell</i>	

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

MEDICAL CERTIFICATION

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 *Bill J. Cherry* .....  
Licensed Embalmer No. *4679* .....  
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.