

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-008464

STATE FILE NUMBER

FILED MAR 30 1959 Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 296

300
-57

1. PLACE OF DEATH a. COUNTY <i>Buchanan</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Buchanan</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Joseph</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>St. Joseph</i> <i>0117</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 <i>125 Gideon J. St.</i>		Length of stay in lb <i>Life</i>	d. STREET ADDRESS (If outside, give location) <i>125 Gideon J. St.</i> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>George</i> Middle <i>William</i> Last <i>Cross</i>			4. DATE OF DEATH Month <i>March</i> Day <i>21</i> Year <i>1959</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 25, 1887</i>
9. AGE (In years) Last birthday <i>78</i>		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) <i>Retired Grocer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Retail Grocery</i>	11. BIRTHPLACE (City and state or country) <i>Buchanan County, Mo.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13a. FATHER'S NAME <i>John Cross</i>	
13b. MOTHER'S MAIDEN NAME <i>Armanda Keling</i>		14. NAME OF HUSBAND OR WIFE <i>Nancy Cross</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Mrs. Nancy Cross</i>		Address <i>St. Joseph, Mo. 125 Gideon J. St.</i>	
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>Carcinoma of the Stomach</i>			INTERVAL BETWEEN ONSET AND DEATH <i>16 months</i>
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) <i>151X</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <i>2</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.) <i>151X</i>	
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 <i>St. Joseph</i>		COUNTY <i>Missouri</i> STATE <i>Missouri</i>	
21. I attended the deceased from <i>3-19-58</i> to <i>3/20/59</i> and last saw her/him alive on <i>3/20/59</i> Death occurred at <i>10:55 p</i> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>John R. McDaniel M.D.</i>		22b. ADDRESS <i>902 Edmond St. St. Joseph, Mo.</i>	
22c. DATE SIGNED <i>3/23/59</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>March 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>Clark Funeral Home</i>		ADDRESS <i>St. Joseph, Mo.</i>	
25. DATE RECD. BY LOCAL REG. <i>Mar. 24, 1959</i>		26. REGISTRAR'S SIGNATURE <i>Wm. Clark Woodell</i>	

All diseases in Part I must be causally related.
 Dr. John R. McDaniel
 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 *Paul F. Clark*

Licensed Embalmer No. *5024*

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.