

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-020474

FILED JUL 13 1959

042

1000

696

STATE FILE NUMBER

UNDECEASED

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Buchanan				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Buchanan			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in 1b most of life		c. CITY OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Thompson-Brumm-Knepper Clinic Hospital				d. STREET ADDRESS (If outside, give location) 2719 Patee St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle E. Last MAIN, SR.				4. DATE OF DEATH Month July Day 6 Year 1959			
5. SEX male	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11/23/1894	9. AGE (last birthday) 64	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Laborer		10b. KIND OF BUSINESS OR INDUSTRY Packing Plant		11. BIRTHPLACE (City and state or country) Lenora, Kansas		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Joseph Main			13b. MOTHER'S MAIDEN NAME Isabel Borthwick			14. NAME OF HUSBAND OR WIFE Cora F. Main	
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. 500-07-4686		17. INFORMANT Mrs. Cora Main, 2719 Patee, St. Joseph, Mo.			
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of prostate						INTERVAL BETWEEN ONSET AND DEATH 4 years	
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)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
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.)					
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____							
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		COUNTY _____	STATE _____
21. I attended the deceased from Nov. 21, 1955 to July 6, 1959 and last saw him alive on July 5, 1959 Death occurred at 3:30a. m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) H. F. Warren M.D.				22b. ADDRESS St. Joseph, Mo.			22c. DATE SIGNED 7/7/59
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 7/9/1959	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery		23d. LOCATION (City, town, or county) St. Joseph Mo.		(State)
24. FUNERAL DIRECTOR Heston Bowman, St. Joseph, Mo.				25. DATE RECD. BY LOCAL REG. July 8, 1959		26. REGISTRAR'S SIGNATURE Mr. Clark Goodell	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

6561 6 JES
SEP 9 1959

20/11/59

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Anthony A. Smith*

Licensed Embalmer No. 3927

P. O. Address 319 E 10th St
St Joseph

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.