

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024228

FILED VS JUL 27 1959

1000

730

STATE FILE NUMBER

Registration District No. 042 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 Missouri b. COUNTY Buchanan		
b. CITY (If outside corporate limits, give TOWNSHIP only) 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 2705 Lafayette St Wyatt Park N. Home		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1020 No. 9th street		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First CARRIE Middle ELENORA Last KNAPP			4. DATE OF DEATH Month July Day 16 Year 1959		
5. SEX Female	6. COLOR OR RACE Caucasian	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11-10-1877	9. AGE (last birthday) 81 yrs.	IF UNDER 1 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 of the home	11. BIRTHPLACE (City and state or country) Fair Field, Iowa	12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Albert Stark		13b. MOTHER'S MAIDEN NAME Maggie Sears		14. NAME OF HUSBAND OR WIFE Linly O. Knapp, (deceased)	
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 1116 So. 17th St., Mr. Charley Reaves, St. Joseph, Missouri		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Cerebral vascular accident					4 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					
DUE TO (b) Hypertensive cardiovascular disease					
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 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	COUNTY	STATE
21. I attended the deceased from January 3, 1959 to July 16, 1959 and last saw her/him alive on July 16, 1959 Death occurred at 8:30 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE E. Handler (Degree or title) MD			22b. ADDRESS St. Joseph, Missouri		22c. DATE SIGNED 7-17-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE July, 18, 1959	23c. NAME OF CEMETERY OR CREMATORY Ashland Cemetery	23d. LOCATION (City, town, or county) (State) St. Joseph, Missouri		
24. FUNERAL DIRECTOR Stamper Funeral Home (GAS) ADDRESS St. Joseph, Mo.		25. DATE RECD. BY LOCAL REG. July 20, 1959	26. REGISTRAR'S SIGNATURE Mr. Clark Goodell		

DOCUMENT

BY AFFIDAVIT OF E. Handler, M.D. 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 _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Charles E. Bennett

Licensed Embalmer No. 4677

P. O. Address 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.