

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024255

FILED VS AUG 17 1959

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STATE FILE NUMBER

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|---|---|---|--|--|--|--|---|
| 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 13 years | | 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 1208 Powell | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 1208 Powell | | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First ELLA Middle SMITH Last POWELL | | | | 4. DATE OF DEATH Month August Day 5 Year 1959 | | | |
| 5. SEX female | 6. COLOR OR RACE white | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 2/13/1867 | 9. AGE (last birthday) 92 | 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) housewife | | | 10b. KIND OF BUSINESS OR INDUSTRY own home | | 11. BIRTHPLACE (City and state or country) Platte County, Mo. | | 12. CITIZEN OF WHAT COUNTRY USA |
| 13a. FATHER'S NAME William Kay | | | 13b. MOTHER'S MAIDEN NAME Emalie Samuel | | | 14. NAME OF HUSBAND OR WIFE C. Fletcher | |
| 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 St. Joseph, Mo. Mrs. A. L. Spugnardi, 1208 Powell | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerosis grand | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 5 1/2 |
| 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 1958 to 8-5-59 and last saw her alive on 8-3-59 Death occurred at 6:15p. m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Degree or title) Clara C. Spugnardi M.D. | | | | 22b. ADDRESS St. Joseph Mo | | | 22c. DATE SIGNED 8-6-59 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) burial | | 23b. DATE 8/8/1959 | 23c. NAME OF CEMETERY OR CREMATORY Agency Cemetery | | 23d. LOCATION (City, town, or county) Agency Missouri | | (State) |
| 24. FUNERAL DIRECTOR Newton Bowman, St. Joseph, Mo. | | | | 25. DATE RECD. BY LOCAL REG. Aug 7, 1959 | | 26. REGISTRAR'S SIGNATURE Mrs. Clara Goodell | |

DOCUMENT

C.C. DuMont M.D. CERTIFICATION

BY AFFIDAVIT OF

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

Eugene Wood

Licensed Embalmer No. *3204*

P. O. Address *314 So 12th, Okla*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.