

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024264

FILED VS AUG 3 1959

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 758

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Buchanan				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Carroll									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in 1b 31 Yrs		c. CITY OR TOWN Wakenda		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hosp. # 2			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) None		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last Eda A Smith				4. DATE OF DEATH July 26, 1959									
5. SEX Female		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 7-26-1368		9. AGE (last birthday) 91		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (City and state or country) Germany		12. CITIZEN OF WHAT COUNTRY ?					
13a. FATHER'S NAME Not Known				13b. MOTHER'S MAIDEN NAME Not Known				14. NAME OF HUSBAND OR WIFE Not Known					
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 State Hosp. Records St. Joseph, Mo.							
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) Coronary Thrombosis										Months			
DUE TO (b) Diabetes Mellitus										Years(?)			
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 checked="" 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 July 26, 1957 to July 26, 1959 and last saw her alive on July 26, 1959													
Death occurred at 6:30 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <i>Mohammed Tahir M.D.</i>						22b. ADDRESS State Hosp. # 2 St. Joseph, Mo			22c. DATE SIGNED 7-26-59				
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 7-27-59		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town, or county) (State) Carrollton, Mo.					
24. FUNERAL DIRECTOR <i>H.O. Sidiyasa & Son</i>				ADDRESS St. Joseph, Mo.		25. DATE RECD. BY LOCAL REG. July 27, 1959		26. REGISTRAR'S SIGNATURE <i>Wm Clark Goodell</i>					

DOCUMENT

BY AFFIDAVIT OF M. Tahir, 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 Robert L. Gaylor

Licensed Embalmer No. 3308

P. O. Address: St. Joseph, Mo.

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. [Signature]
If this body is not embalmed, fact should be so stated above.