

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024279

FILED VS JUL 20 1959 042

Registration District No. _____ Primary Registration District No. 1000 Registrar's No. 721

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY Buchanan b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph Length of stay in 1b 26 years c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Meth. Hosp. Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Buchanan c. CITY OR TOWN St. Joseph Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) 1315 Ridenbaugh Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
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3. NAME OF DECEASED (Type or print) First LOULA Middle AUGUSTA Last WILLMORE			4. DATE OF DEATH Month July Day 11 Year 1959		
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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 5/12/1882	9. AGE (last birthday) 77	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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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) Udahl, Kansas	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME Jim Roe Brinegar	13b. MOTHER'S MAIDEN NAME Kate Hornbeak	14. NAME OF HUSBAND OR WIFE Fred H. Willmore
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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. Margaret Brackett, 1317 Ridenbaugh
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intra cranial Hemorrhage DUE TO (b) Hypertension arterial DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 6 days 1 mo. +
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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
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year _____	
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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
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21. I attended the deceased from **7-6-59** to **7-11-59** and last saw her alive on **7-11-59**
 Death occurred at **2:37 p.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) H.C. Senne MD	22b. ADDRESS 207 PWS Bld, St. Joseph Mo	22c. DATE SIGNED 7-11-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 7/14/1959	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	23d. LOCATION (City, town, or county) (State) St. Joseph Mo.
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24. FUNERAL DIRECTOR ADDRESS Horton-Brown, St. Joseph, Mo.	25. DATE RECD. BY LOCAL REG. July 16, 1959	26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF H.C. SENNE, M.D.

MB

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

William Spalding

Licensed Embalmer No. 4535

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.

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