

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024281

FILED VS JUL 20 1959

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 719

STATE FILE NUMBER

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 20 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 Mo. Meth. Hosp.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 920 Alabama		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MILLARD Middle JOHNSON Last WITHAM				4. DATE OF DEATH Month July Day 10 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 7/17/1898	9. AGE (last birthday) 60	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Stock Yards		11. BIRTHPLACE (City and state or country) Vermillion, Kansas		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME William H. Witham			13b. MOTHER'S MAIDEN NAME Eva Ellen Miller		14. NAME OF HUSBAND OR WIFE Lola G.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes W.W.#11		16. SOCIAL SECURITY NO. 500-14-7925		17. INFORMANT Address Mrs. Lola Witham, 920 Alabama, St. Joseph, Mo			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion						INTERVAL BETWEEN ONSET AND DEATH 3 days	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Post operati, gastric resection, subtotal						4 days	
DUE TO (c) Arteriosclerotic heart disease							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Rudernal ulcer obstructing					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 checked="" type="checkbox"/> NO <input 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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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 4 July 1959 , to death and last saw him alive on 10 July 1959 Death occurred at 5:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Walter P. McDonald, M.D.				22b. ADDRESS 301 N. 8th St. Joseph		22c. DATE SIGNED 18 July '59	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 7/13/1959	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery		23d. LOCATION (City, town, or county) (State) St. Joseph, Missouri		
24. FUNERAL DIRECTOR Hatow-Bowman			ADDRESS St. Joseph, Mo.		25. DATE RECD. BY LOCAL REG. July 16, 1959	26. REGISTRAR'S SIGNATURE Mrs. Clark Goodall	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

W. P. McDONALD, M.D.

6335 6 8 707

6361 6 8 707

6335 6 8 707

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 9

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.