

REGISTRATION DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028216

FILED MS SEP 14 1959 042

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STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Clay</b>						
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph, Missouri</b>		Length of stay in 1b <b>3yr 5m 9d</b>		c. CITY OR TOWN <b>Excelsior Springs, Mo.</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>				
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>State Hospital #2</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>213 Dunbar</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Thompson</b> Last <b>Clariday</b>				4. DATE OF DEATH Month <b>Sept</b> Day <b>4</b> Year <b>1959</b>						
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>Mar 24, 1872</b>		9. AGE (last birthday) <b>87</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (City and state or country) <b>Indiana</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.		
13a. FATHER'S NAME <b>Joseph Clariday</b>			13b. MOTHER'S MAIDEN NAME <b>Emily Francis Lombert</b>			14. NAME OF HUSBAND OR WIFE <b>Gertrude Clariday</b>			Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>			16. SOCIAL SECURITY NO. <b>Unknown</b>			17. INFORMANT <b>State Hospital #2 Records St. Joseph</b>			Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b>								INTERVAL BETWEEN ONSET AND DEATH <b>48 hour 5</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <b>CBS. Assoc with Senite Br. Decease</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 <b>June 8, 1959</b> to <b>Sept 4, 1959</b> and last saw him alive on <b>Sept 4, 1959</b> Death occurred at <b>Sept 4, 1959</b> <b>4:15 PM</b> on the date stated above, and to the best of my knowledge, from the causes stated.										
22a. SIGNATURE (Degree or title) <b>R.P. Price M.D.</b>				22b. ADDRESS <b>State Hospital #2</b>				22c. DATE SIGNED <b>9-4-1959</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>9/5/1959</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Richmond Mo.</b>		23d. LOCATION (City, town, or county) (State)				
24. FUNERAL DIRECTOR <b>Heaton Bauman</b>			ADDRESS <b>St. Joseph, Missouri</b>			25. DATE RECD. BY LOCAL REG. <b>Sept. 8, 1959</b>		26. REGISTRAR'S SIGNATURE <b>Mrs. Clark Goodell</b>		

DED

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION  
R.P. Price, M.D.

**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. 3804

P. O. Address 319 S. 10th St.

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.