

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028277

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STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

|  |   |   |  |   |  |  |   |
|--|---|---|--|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Buchanan</b>   |   |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Euchanan</b> |  |  |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN <b>St. Joseph</b>  |   | Length of stay in lb<br><b>12 years</b>   |  | c. CITY OR TOWN <b>St. Joseph</b>   |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>St. Joseph's Hospital</b>  |   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location)<br><b>1609 East Highland</b>  |  |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Fannie</b> Middle <b>Beatrice</b> Last <b>White</b>   |   |   |  | 4. DATE OF DEATH<br>Month <b>Aug.</b> Day <b>7,</b> Year <b>1959</b>  |  |  |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>July 9, 1897</b>   | 9. AGE (last birthday)<br><b>62</b>  | IF UNDER 1 YEAR<br>Months _____ Days _____ Hours _____ Min. _____                    | IF UNDER 24 HR<br>Hours _____ Min. _____  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Checker</b>  |   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Getchell Laundry</b>                         |   | 11. BIRTHPLACE (City and state or country)<br><b>Sheridan, Missouri</b>  |  | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>  |
| 13a. FATHER'S NAME<br><b>John C. White</b>   |   |   | 13b. MOTHER'S MAIDEN NAME<br><b>unknown</b>  |   |  | 14. NAME OF HUSBAND OR WIFE<br><b>unknown</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>   |   | 16. SOCIAL SECURITY NO.<br><b>unknown</b>   |  | 17. INFORMANT<br>Address<br><b>Marie Thummel, Parnell, Missouri</b>   |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Ventricular fibrillation</b>  |   |   |  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>minutes</b>                                    |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <b>Myocardial infarction.</b>   |   |   |  |   |  |  | <b>7/29/59</b>  |
| DUE TO (c) <b>ASHD with coronary thrombosis.</b>   |   |   |  |   |  |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>Multiple cardiac arrhythmias due to the infarct; cholecystitis.</b>                            |   |   |  |   | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |  |   |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>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>7/29/59</b> to <b>8/6/59</b> and last saw her/him alive on <b>8/6/59</b><br>Death occurred at <b>12:15</b> A. m on the date stated above, and to the best of my knowledge, from the causes stated. |   |   |  |   |  |  |   |
| 22a. SIGNATURE<br><i>Caryl A. Potter, M.D.</i><br>(Type or print)  |   |   | 22b. ADDRESS<br><b>Phy. &amp; Surg. Bldg.-St. Joseph, Mo.</b>                        |   |  | 22c. DATE SIGNED<br><b>8/26/59</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>  | 23b. DATE<br><b>Aug. 7, 1959</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Isadore Cemetery</b>   |  | 23d. LOCATION (City, town, or county)<br><b>Isadore, Missouri</b>   |  |  | (State)   |
| 24. FUNERAL DIRECTOR<br><b>Neuschaffer-Hecan Co.</b><br>Address<br><b>St. Joseph, Mo.</b>  |   |   | 25. DATE RECD. BY LOCAL REG.<br><b>Aug. 27, 1959</b>                                 |   | 26. REGISTRAR'S SIGNATURE<br><i>Wm. Clark Goodell</i>  |  |   |

DOCUMENT

BY AFFIDAVIT OF MEDICAL CERTIFICATION  
*C.A. Potter, 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 

Licensed Embalmer No. 467

P. O. Address 570

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.