

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-031494

FILED VS SEP 28 1959

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STATE FILE NUMBER

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

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>Buchanan</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>		Length of stay in 1b <b>45 yrs.</b>		c. CITY OR TOWN <b>St. Joseph</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>D.O.A. Mo. Methodist Hosp.</b>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>4016 Pickett Rd.,</b>	
3. NAME OF DECEASED (Type or print) First <b>Dorothy</b> Middle <b>C. Hanna</b> Last <b>Brown</b>				4. DATE OF DEATH Month <b>Sept.</b> Day <b>19,</b> Year <b>1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 25, 1906</b>	9. AGE (last birthday) <b>53</b>		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (City and state or country) <b>Brookfield, Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>James Berry Hanna</b>			13b. MOTHER'S MAIDEN NAME <b>Josephine Crowner</b>		14. NAME OF HUSBAND OR WIFE <b>James H. Brown</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>486-30-4270</b>		17. INFORMANT Address <b>James H. Brown, St. Joseph, Missouri</b>			
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 occlusion</b> DUE TO (b) <b>Coronary sclerosis</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <b>hours</b> <b>under</b>	
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>May 59</b> to <b>9-19-59</b> and last saw her alive on <b>9-19-59</b> Death occurred at <b>11:30 P.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Clement C. [Signature]</b>				22b. ADDRESS <b>St. Joseph, Mo</b>			22c. DATE SIGNED <b>9-22-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>Sep. 22, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Joseph, Missouri</b>		
24. FUNERAL DIRECTOR <b>[Signature]</b> <b>St. Joseph, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>Sept. 23, 1959</b>		26. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

DOCUMENT

BY AFFIDAVIT OF C.S. DeMont, 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 E. Herking

Licensed Embalmer No. 3258

P. O. Address St. Joseph

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.