

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-031496

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 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 lb 2 days		c. CITY OR TOWN Easton		Inside Limits Yes <input type="checkbox"/> No <input checked="" 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) R. R. #1			Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First DORA Middle ALMINA Last BURCH				4. DATE OF DEATH Month Sept. Day 17, Year 1959			
5. SEX female	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 2/4/1891	9. AGE (last birthday) 68	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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) Buchanan County, Mo.		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME William Watkins			13b. MOTHER'S MAIDEN NAME Margaret Jones			14. NAME OF HUSBAND OR WIFE Harry S.	
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. 496-42-3407		17. INFORMANT Address Mr. Harry S. Burch, R.R. #1, Easton, 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) acute coronary occlusion and myocardial infarction due to						INTERVAL BETWEEN ONSET AND DEATH 45 min.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) arteriosclerotic heart disease & heart block at least 5 yrs				DUE TO (c) hypertensive cardiovascular disease at least 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) hemorrhagic callosities of gran. sept with abnormal bleeding and hemorrhagic callosities myoma of uterus & abd. bleeding						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	
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 Month, Day, Year a.m. p.m.		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 7-8-54 to 9-17-59 and last saw her ^{him} alive on 9-17-59 Death occurred at 6:50 p. m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Thompson P. Potter, M.D.				22b. ADDRESS 731 FARAOW ST. ST. JOSEPH, MO.		22c. DATE SIGNED 9-19-59	
23a. BURIAL CREMATION, REMOVAL (Specify) burial		23b. DATE 9/20/1959	23c. NAME OF CEMETERY OR CREMATORY Allen Cemetery		23d. LOCATION (City, town, or county) Gover Missouri		(State)
24. FUNERAL DIRECTOR Walter-Bowman			ADDRESS St. Joseph, Mo.		25. DATE RECD. BY LOCAL REG. Sept 21, 1959	26. REGISTRAR'S SIGNATURE Mrs. Clark Swadell	

DOCUMENT

BY AFFIDAVIT OF T.E. Potter, M.D. 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 Eugene Wood

Licensed Embalmer No. 3804

P. O. Address 3196 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.