RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

59-031526

FILED VS OCT 13 1959

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 1010

STATE FILE NUMBER

DED

1. PLACE OF DEATH
a. COUNTY: Buchanan
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Joseph — Length of stay in 1b: most of life
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: St. Josephs Hospital — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo. b. COUNTY: Buchanan
c. CITY OR TOWN: St. Joseph — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 2824 Penn St. — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: MARGARET Middle: E. Last: HOWARD

4. DATE OF DEATH: Month: September Day: 30 Year: 1959

5. SEX: female
6. COLOR OR RACE: white
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: May 17, 1915
9. AGE (last birthday): 44 — IF UNDER 1 YEAR: Months / Days — 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): DeKalb, Mo.
12. CITIZEN OF WHAT COUNTRY: USA

13a. FATHER'S NAME: Thomas Roberts
13b. MOTHER'S MAIDEN NAME: Edith Scott
14. NAME OF HUSBAND OR WIFE: Cleo L. Howard

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): ----
16. SOCIAL SECURITY NO.: 491-09-3664
17. INFORMANT: Cleo L. Howard, Address: 2824 Penn, 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): METASTATIC CARCINOMA — INTERVAL BETWEEN ONSET AND DEATH: 1 YR.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b): CARCINOMA OVARIES — 1 1/2 YRS
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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 7/12/1954, to 9/30/59 and last saw her/him alive on 9/30/59
Death occurred at 11:00p. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): John T. Rogers M.D. — 22b. ADDRESS: 307 Kirkpatrick Bldg St. Joe Mo. — 22c. DATE SIGNED: 10/7/59

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE: 10/3/1959
23c. NAME OF CEMETERY OR CREMATORY: Memorial Park Cemetery
23d. LOCATION (City, town, or county) (State): St. Joseph, Mo.

24. FUNERAL DIRECTOR: Heston Bowman — ADDRESS: St. Joseph, Mo.
25. DATE RECD. BY LOCAL REG.: Oct. 9, 1959
26. REGISTRAR'S SIGNATURE: Mrs. Clark Goodell

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF MEDICAL CERTIFICATION

John T. Rogers M.D.

NOV 20 1959

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_____ Signed William Spelling
Signature of Student Embalmer

Licensed Embalmer No. 4535

P. O. Address St Joseph, S

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co
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.