

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-031563

FILED VS OCT 13 1959 042

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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 Missouri b. COUNTY Buchanan					
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in 1b 72 yrs.		c. CITY OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION 219 North 12th St.,			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (if outside, give location) 219 North 12th St.,		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Nancy Middle (Davis) Last Seymour				4. DATE OF DEATH Month September Day 30 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 Dec. 11, 1875	9. AGE (last birthday) 83	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) Plattsburg, Missouri		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME William Frank Davis			13b. MOTHER'S MAIDEN NAME Virginia Bird Asbury			14. NAME OF HUSBAND OR WIFE William Henson Seymour			
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. 493-38-8908B		17. INFORMANT William Henson Seymour, St. Joseph, Mo.				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) Coronary Refarction Coronary Sclerosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH Immediate ?		
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 Sept-30-59 to _____ and last saw her Sept-30-59 alive or _____ Death occurred at 3:30 P. m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) T.R. Howden M.D.				22b. ADDRESS 419 Kirkpatrick St.			22c. DATE SIGNED Oct-2-59		
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE Oct. 2, 1959	23c. NAME OF CEMETERY OR CREMATORY Mt. Mora Cemetery		23d. LOCATION (City, town, or county) (State) St. Joseph, Missouri					
24. FUNERAL DIRECTOR Meacham-Henning St. Joseph, Mo.			25. DATE RECD. BY LOCAL REG. Oct. 7, 1959		26. REGISTRAR'S SIGNATURE Wm. Clark Standell				

DOCUMENT

BY AFFIDAVIT OF T.R. Howden, M.D. MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Albert B. Harvey

Licensed Embalmer No. 325

P. O. Address St. Joe

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