

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-031575

FILED VS SEP 21 1959 042

Registration District No. _____ Primary Registration District No. 1000 Registrar's No. 927

STATE FILE NUMBER

INDEXED

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 60 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 St. Joseph's Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1216 No. 9th St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First EDWARD Middle GRANT Last WEDDLE				4. DATE OF DEATH Month September Day 12, Year 1959					
5. SEX Male	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 9-13-1872	9. AGE (last birthday) 87	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) Ret. (15) Electrician			10b. KIND OF BUSINESS OR INDUSTRY St. Joseph Lt. & Pr.		11. BIRTHPLACE (City and state or country) Easton, Mo.		12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME Alvin Weddle			13b. MOTHER'S MAIDEN NAME Martha Daniels			14. NAME OF HUSBAND OR WIFE Ethel Weddle			
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. 491-09-7292		17. INFORMANT Ethel Weddle 1216 No. 9th City				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>arteriosclerosis</u> 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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown							INTERVAL BETWEEN ONSET AND DEATH 3 days under		
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 _____ 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 1956 to 9-12-59 and last saw ^{her} him alive on 9-12-59 Death occurred at 2:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>Clemens C. DiMonte M.D.</u> (Degree or title)				22b. ADDRESS St. Joseph Mo				22c. DATE SIGNED 9-14-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Sept. 15, 59	23c. NAME OF CEMETERY OR CREMATORY St. Joseph's Cemetery		23d. LOCATION (City, town, or county) Easton, Mo.			(State)	
24. FUNERAL DIRECTOR H.O. Sidenfaden & Son RR4.			ADDRESS St. Joseph, Mo.		25. DATE RECD. BY LOCAL REG. Sept. 15, 1959		26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell		

DOCUMENT

C.C. DiMonte, M.D.

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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Robert H. Gaylor

Licensed Embalmer No. 3308

P. O. Address St. Joseph, Mo.

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.