

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-035247

FILED VS OCT 26 1959

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STATE FILE NUMBER

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

ENDED

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Kansas</b> b. COUNTY <b>Nemaha</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>		Length of stay in 1b <b>10 weeks</b>	c. CITY OR TOWN <b>Kelly</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital or institution) <b>180 Faraon St. Goforth Nursing Home</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>Kelly, Kansas</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>James</b> Last <b>Fleming</b>	4. DATE OF DEATH Month <b>October</b> Day <b>10</b> Year <b>1959</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 9, 1876</b>	9. AGE (last birthday) <b>83</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	11. BIRTHPLACE (City and state or country) <b>Jackson Co., Kansas</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>John Fleming</b>	13b. MOTHER'S MAIDEN NAME <b>Anna Cummings</b>	14. NAME OF HUSBAND OR WIFE <b>Mary Fleming</b>
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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>none</b>	17. INFORMANT <b>Mrs. Warren Ice</b> Address <b>St. Joseph, Mo.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a) and (b) and (c) if applicable) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>2) Adenocarcinoma of Prostate - 3 1/2 yrs +</b>		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
Conditions, if any, which gave rise to above cause (e), stating the underlying cause last.	DUE TO (b) _____ DUE TO (c) _____	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Arteriosclerosis, generalized</b>		
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year _____
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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 _____
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21. I attended the deceased from **4/18/56** to **10/10/59** and last saw him alive on **9/27/59**  
Death occurred at **4 A.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Wm Redmond MD</b> (Degree or title)	22b. ADDRESS <b>St Joseph, Mo</b>	22c. DATE SIGNED <b>10/15/59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>Oct. 10, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Bede's Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Kelly, Kansas.</b>
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24. FUNERAL DIRECTOR ADDRESS <b>Meuchoffer - Freeman, St. Joseph, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>Oct. 16, 1959</b>	26. REGISTRAR'S SIGNATURE <b>Mrs. Clark Goodell</b>
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DOCUMENT

BY AFFIDAVIT OF W.M. REDMOND, M.D. MEDICAL CERTIFICATION

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**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 Albert C. Harrington

Licensed Embalmer No. 3-251

P. O. Address St. Joe

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.