

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-035248

FILED VS. NOV 2 1959 042

Primary Registration District No. 1000 Registrar's No. 1090

STATE FILE NUMBER

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY Buchanan		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		a. STATE Missouri		b. COUNTY Buchanan	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1818 Savannah Ave.,		Length of stay in 1b 16 years		c. CITY OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. STREET ADDRESS 1818 Savannah Avenue		e. INSIDE LIMITS Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1818 Savannah Avenue		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First OMER		Middle LEE		Last FRAME		Month Day Year October 27, 1959	
5. SEX Male	6. COLOR OR RACE Caucasian	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9/25/1912	9. AGE (last birthday) 47 years	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (City and state or country) Bedford, Missouri		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME O. K. Frame			13b. MOTHER'S MAIDEN NAME Ethel Saunders			14. NAME OF HUSBAND OR WIFE None	
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. None		17. INFORMANT Mrs. Ethel Frame, St. Joseph, Missouri			
18. CAUSE OF DEATH (Enter only one cause by line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:						INTERVAL BETWEEN ONSET AND DEATH 36 hrs	
IMMEDIATE CAUSE (a) Intestinal obstruction							
DUE TO (b) (Do not know the cause - First examined him 15 hrs. before death)							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Severe spinal deformity. Deaf & dumb. Absence of rt. ear - wt. about 60 lbs.						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.) Congenital defects.			
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 10-27-59 to 10-27-59 and last saw her alive on 10-27-59 Death occurred at 10:00 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE C. S. Grant M.D. (Degree or title)				22b. ADDRESS St. Joseph, Mo.		22c. DATE SIGNED 10/28/59 (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 10/30/1959	23c. NAME OF CEMETERY OR CREMATORY Avalon Cemetery		23d. LOCATION (City, town, or county) Avalon, Missouri		
24. FUNERAL DIRECTOR Stamie Funeral Home		ADDRESS St. Joseph, Mo.		25. DATE RECD. BY LOCAL REG. Oct. 30, 1959	26. REGISTRAR'S SIGNATURE Mrs. Clark Goodall		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF C. S. GRANT, M.D.

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

Charles E. Bennett

Licensed Embalmer No. 4677

P. O. Address St Joseph

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.