

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-035259

FILED VS. OCT 19 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 b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph Length of stay in 1b 38 years 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"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan c. CITY OR TOWN St. Joseph Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) 2818 Whitman Dr. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Wilbur Middle Lynn Last Hegarty			4. DATE OF DEATH Month Oct. Day 8, 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 June 11, 1902	9. AGE (last birthday) 57	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) Exec. V-P of Production, Goetz Brewery		10b. KIND OF BUSINESS OR INDUSTRY Wathena, Ks.		11. BIRTHPLACE (City and state or country) USA		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Samuel H. Hegarty		13b. MOTHER'S MAIDEN NAME Nellie Wilkinson		14. NAME OF HUSBAND OR WIFE Alice (Rice) Hegarty			
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. 491-09-9112		17. INFORMANT Address Mrs. Alice Hegarty 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) Hemorrhage from Esophageal Varices INTERVAL BETWEEN ONSET AND DEATH 14 days DUE TO (b) Cirrhosis of Liver 12 yrs. DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							
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 checked="" type="checkbox"/> NO <input 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 27, 1959 1:10 A. to Oct 8, 1959 and last saw her/him alive on Oct 8, 1959 Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.							
22. SIGNATURE (Degree or title) John R. McDaniel, M.D.			22b. ADDRESS 902 Edmond St, St Joseph		22c. DATE SIGNED 10/12/59		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Oct. 10, 1959	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town, or county) (State) St. Joseph, Missouri.			
24. FUNERAL DIRECTOR ADDRESS Meierhoffer Fleeman, Inc, St. Joseph, Mo.			25. DATE RECD. BY LOCAL REG. Oct. 13, 1959	26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell			

DOCUMENT

BY AFFIDAVIT OF

J.P. McDaniel, M.D. CERTIFICATION

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 E. Harrington

Licensed Embalmer No. 9235

P. O. Address St. Jose

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.