

**URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-039027**

**FILED VS NOV 23 1959**

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STATE FILE NUMBER

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

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <b>Buchanan</b>	a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>	Length of stay in 1b <b>30 years</b>	c. CITY OR TOWN <b>St. Joseph</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>2121 Eugene Field Ave</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>2121 Eugene Field Ave</b>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

<b>3. NAME OF DECEASED</b> (Type or print)	First <b>Ella</b>	Middle <b>Bailey</b>	Last <b>McHugh</b>	<b>4. DATE OF DEATH</b>	Month <b>November</b>	Day <b>16,</b>	Year <b>1959</b>
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<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>Jan. 19, 1868</b>	<b>9. AGE (last birthday)</b> <b>91</b>	<b>IF UNDER 1 YEAR</b> Months _____ Days _____	<b>IF UNDER 24 HR</b> Hours _____ Min. _____
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<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Ret. Teacher &amp; Housewife</b>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b>	<b>11. BIRTHPLACE</b> (City and state or country) <b>Pittsfield, Illinois.</b>	<b>12. CITIZEN OF WHAT COUNTRY</b> <b>USA</b>
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<b>13a. FATHER'S NAME</b> <b>Christopher C. Bailey</b>	<b>13b. MOTHER'S MAIDEN NAME</b> <b>Lucinda Simpson</b>	<b>14. NAME OF HUSBAND OR WIFE</b> <b>James Boyd McHugh</b>
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<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	<b>16. SOCIAL SECURITY NO.</b> <b>none</b>	<b>17. INFORMANT</b> <b>Miss. Charline McHugh</b>	<b>Address</b> <b>St. Joseph, Mo.</b>
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<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		<b>INTERVAL BETWEEN ONSET AND DEATH</b>
IMMEDIATE CAUSE (a)	<b>Arterio Sclerotic Heart Disease</b>	<b>Unknown</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	<b>Arterio Sclerosis General</b>
	DUE TO (c)	<b>Unknown</b>
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

<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)
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<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m.	Month, Day, Year _____
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<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b>	<b>COUNTY</b>	<b>STATE</b>
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**21. I attended the deceased from** August 18 - 1959 **to** November 16 - 1959 **and last saw her** her **alive on** November 16 - 1959  
**Death occurred at** 5:30 P.M. **on the date stated above, and to the best of my knowledge, from the causes stated.**

<b>22a. SIGNATURE</b> <i>Austav H. Lau</i>	(Degree or title) <b>M.D.</b>	<b>22b. ADDRESS</b> <b>Kukpatuck Bldg. St. Joseph Missouri</b>	<b>22c. DATE SIGNED</b> <b>Nov. 17 - 1959</b>
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<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>	<b>23b. DATE</b> <b>Nov. 18, 1959</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Memorial Park Cemetery</b>	<b>23d. LOCATION</b> (City, town, or county) <b>St. Joseph, Missouri.</b>
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<b>24. FUNERAL DIRECTOR</b> <i>Pfeifferhoff - Flanagan</i>	<b>ADDRESS</b> <b>St. Joseph, Mo.</b>	<b>DATE RECD. BY LOCAL REG.</b> <b>Nov. 19, 1959</b>	<b>26. REGISTRAR'S SIGNATURE</b> <i>Wm. Clark Bradell</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

G.H. Layman, Jr.

**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 *Edward R. Hawn*

Licensed Embalmer No. 3258

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.