

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-039040

FILED VS DEC 14 1959 042

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1225

STATE FILE NUMBER

Registration District No. 042 Primary Registration District No. Registrar's No.

ENDED

1. PLACE OF DEATH a. COUNTY BUCHANON				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY HARRISON				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. JOSEPH		Length of stay in 1b 7YR		c. CITY OR TOWN BETHANY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF HOSPITAL OR INSTITUTION STATE HOSPITAL #2			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) NONE		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ESTHER Middle ANNA Last PEETOOM				4. DATE OF DEATH Month 12 Day 5 Year 1959				
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 1-31-1877	9. AGE (last birthday) 82	IF UNDER 1 YEAR Months 10 Days 4	IF UNDER 24 HR Hours Min. 	
10a. USUAL OCCUPATION (Give time of work done during most of working life, even if retired) HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (City and state or country) HARRISON COUNTY, MO.		12. CITIZEN OF WHAT COUNTRY U. S.	
13a. FATHER'S NAME JOHN L. WILSON			13b. MOTHER'S MAIDEN NAME HARRIETT LAWRENCE			14. NAME OF HUSBAND OR WIFE MATICE PEETOOM		
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 H. B. PEETOOM, BETHANY, MO. Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE DUE TO (b) GENERALIZED ARTERIOSCLEROSIS DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH	
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 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 Dec. 5, 1959 , to Dec. 5, 1959 and last saw ^{her} / _{him} alive on Dec. 5, 1959 Death occurred at Dec. 5, 1959, 10:30 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) Mohammod Tahir M.D.				22b. ADDRESS State Hosp. #2 St. Joseph, Mo.			22c. DATE SIGNED 12-6-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 12-6-59	23c. NAME OF CEMETERY OR CREMATORY Haas Funeral Home		23d. LOCATION (City, town, or county) Bethany, Mo.		(State)	
24. FUNERAL DIRECTOR W. B. Haas ADDRESS Bethany, Mo.				25. DATE RECD. BY LOCAL REG. Dec. 8, 1959		26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell		

DOCUMENT

MEDICAL CERTIFICATION

M. Tahir, 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 
M. B. Haas

Licensed Embalmer No. # 3899

P. O. Address Bethany, 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.