

MORTUARY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-039051

FILED VS NOV 23 1959

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STATE FILE NUMBER

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

UNRECORDED

1. PLACE OF DEATH a. COUNTY Buchanan				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Buchanan									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in lb 7 years		c. CITY OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Thompson-Brumm-Knepper Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1320 Francis St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First LEONARD Middle A. Last SAUNDERS				4. DATE OF DEATH Month November Day 14, 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 9/29/1877		9. AGE (last birthday) 82		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) Retired County Extension Agent				10b. KIND OF BUSINESS OR INDUSTRY Gentry County		11. BIRTHPLACE (City and state or country) Andrew County, Mo.		12. CITIZEN OF WHAT COUNTRY USA					
13a. FATHER'S NAME O. B. Saunders				13b. MOTHER'S MAIDEN NAME Mary Combest				14. NAME OF HUSBAND OR WIFE Katie Bartholomew Saunders					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 495-38-7625		17. INFORMANT Address Mrs. L. A. Saunders, 1329 Francis, St. Joseph							
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										INTERVAL BETWEEN ONSET AND DEATH 11 yrs			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) congestive arteriosclerosis										unknown			
DUE TO (c) _____													
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 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.)									
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 10-5-54 , to 11-15-59 and last saw ^{her} him alive on 11-15-59 Death occurred at 3:55p. m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) William H. Ames, MD						22b. ADDRESS 909 Edmund St				22c. DATE SIGNED 11-17-59			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial			23b. DATE 11/16/1959		23c. NAME OF CEMETERY OR CREMATORY Whitesville Cemetery			23d. LOCATION (City, town, or county) (State) Whitesville Missouri					
24. FUNERAL DIRECTOR ADDRESS Shaton-Bowman, St. Joseph, Mo.					25. DATE RECD. BY LOCAL REG. Nov. 19, 1959		26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell						

DOCUMENT

W. H. Ames, M.D. MEDICAL CERTIFICATION

BY AFFIDAVIT OF

3170 10-1-58
The Green

DEC 10 1958

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 William G. Galloway

Licensed Embalmer No. 4535

P. O. Address Bojarsville

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.