

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 4 3 4 1 3

FILED VS JAN 11 1960

042

1000

1339

STATE FILE NUMBER

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

ENDED

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 Jackson
Length of stay in 1b 82 days		c. CITY OR TOWN Kansas City	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hospital # 2		d. STREET ADDRESS 4900 Brighton	Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH	
First GROVER	Middle M	Last MITCHELL	Month December	Day 30
5. SEX Male	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 6/19/1879	9. AGE (last birthday) 80 years
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) Texas	12. CITIZEN OF WHAT COUNTRY America

13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Laura
--------------------------------------	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown	16. SOCIAL SECURITY NO. None	17. INFORMANT Records State Hospital #2, St. Joseph, Mo.
--	--	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Bronchial Pneumonia	24 hrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	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 **Dec. 30, 1959** to **12/30 59** and last saw ^{her}him alive on **Dec. 30, 1959**
Death occurred at **4:55 A.m** on the date stated above, and to the best of my knowledge, from the causes stated.

22. SIGNATURE (Degree or title) R. P. Price M.D.	22b. ADDRESS State Hospital #2 St. Joseph, Mo.	22c. DATE SIGNED 12/30/59
--	--	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 1/3/1959	23c. NAME OF CEMETERY OR CREMATORY Kirksville College Osteopathy, Kirksville Mo.,	23d. LOCATION (City, town, or county) (State)
---	------------------------------	---	---

24. FUNERAL DIRECTOR Home Funeral Home	ADDRESS St. Joseph, Mo.,	25. DATE RECD. BY LOCAL REG. Dec. 31, 1959	26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell
--	------------------------------------	--	--

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

R. P. Price M.D. MEDICAL CERTIFICATION

9/15

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.