

FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

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STATE FILE NUMBER

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

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 1b 50 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 2317 S. 22nd St.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 2317 S. 22nd St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First MIKE Middle _____ Last PREMIS				4. DATE OF DEATH Month December Day 9 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 Jan. 17, 1893		9. AGE (last birthday) 66 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) Barber			10b. KIND OF BUSINESS OR INDUSTRY Barber Shop		11. BIRTHPLACE (City and state or country) Greece		12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME unknown			13b. MOTHER'S MAIDEN NAME unknown			14. NAME OF HUSBAND OR WIFE Pearl E. Premis			
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. 500-36-2606		17. INFORMANT Address Mrs. Pearl Premis, 2317 S. 22nd, 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) Myocardial infarction DUE TO (b) acute coronary occlusion DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH at once at once		
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.) Sudden onset, vomiting, sharp in precordia and arms					
20c. TIME OF INJURY Hour 8:15 a.m. _____ p.m. _____ Month, Day, Year Dec 9-59		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		20f. CITY, TOWN, OR LOCATION St Joseph Buchanan MO		STATE	
21. I attended the deceased from viewed body and last saw him ^{was} alive on Dec 9-59 Death occurred at 8:15a. m on the date stated above, and to the best of my knowledge, from the causes stated.									
22. SIGNATURE (Degree or title) S.F. Meloney M.D.				22b. ADDRESS 214 Kirkpatrick St Joseph Mo Bldg			22c. DATE SIGNED Dec 11-59		
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 12/11/1959		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town, or county) (State) St. Joseph Mo.			
24. FUNERAL DIRECTOR Neaton-Bowman, St. Joseph, Mo.				25. DATE RECD. BY LOCAL REG. Dec. 14, 1959		26. REGISTRAR'S SIGNATURE Wm. Clark Standell			

DOCUMENT

BY AFFIDAVIT OF S.F. Meloney, M.D. MEDICAL CERTIFICATION

DEC 28 1959

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 Theron O Smith

Licensed Embalmer No. 3928

P. O. Address 319 4 10 St
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.