

FBI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 4 3 4 2 8

FILED VS JAN 11 1960 042

Registration District No. _____ Primary Registration District No. 1000 Registrar's No. 1331

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <i>Buchanan</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Buchanan</i>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Joseph</i>		Length of stay in 1b <i>75 years</i>		c. CITY OR TOWN <i>St. Joseph</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>415 Thompson St.</i>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <i>415 Thompson</i>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Johanna</i> Middle _____ Last <i>Smith</i>				4. DATE OF DEATH Month <i>December</i> Day <i>29</i> Year <i>1959</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <i>12/21/1879</i>	9. AGE (last birthday) <i>80</i>	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) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (City and state or country) <i>Cape, England</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13a. FATHER'S NAME <i>W. T. Letts</i>			13b. MOTHER'S MAIDEN NAME <i>Unknown</i>		14. NAME OF HUSBAND OR WIFE <i>Deceased</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT Address <i>Mrs. Bertha E. McLawry 415 Thompson</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vasculan accident</i>							INTERVAL BETWEEN ONSET AND DEATH <i>6 days</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <i>Hypertensive arteriosclerotic cardio-vascular disease.</i>					
		DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Diabetes Mellitus</i>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 <i>8-23-59</i> to <i>12-29-59</i> and last saw her ^{her} alive on <i>12-27-59</i> Death occurred at <i>2:00 a.m.</i> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <i>C.S. Grant M.D.</i>				22b. ADDRESS <i>St. Joseph, Mo.</i>		22c. DATE SIGNED <i>12-30-59</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Dec. 31, 1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Ashland Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>St. Joseph, Mo.</i>		
24. FUNERAL DIRECTOR <i>Clark Funeral Home</i>		ADDRESS <i>St. Joseph, Mo.</i>		25. DATE RECD. BY LOCAL REG. <i>Jan. 4, 1960</i>	26. REGISTRAR'S SIGNATURE <i>Wm. Clark Randall</i>		

DOCUMENT

MEDICAL CERTIFICATION

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

Allan C. Ryan

Licensed Embalmer No. 4795

P. O. Address

St. Joseph, Ma

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.