

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-000313

FILED VS JAN 11 1960

042

Primary Registration District No.

1000

Registrar's No.

7

STATE FILE NUMBER

DED

| | | | | | | | |
|---|--|---|--|---|--|---|------------------------------|
| 1. PLACE OF DEATH a. COUNTY Buchanan | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph | | Length of stay in lb Life | | c. CITY OR TOWN St. Joseph | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 521 No. 19th St. | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 521 No. 19th St. | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last ELIZABETH FOUTS | | | | 4. DATE OF DEATH Month Day Year January 1 1960 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 7/4/1908 | 9. AGE (last birthday) 51 | 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) Librarian | | 10b. KIND OF BUSINESS OR INDUSTRY St. Joseph Hospital | | 11. BIRTHPLACE (City and state or country) St. Joseph, Missouri | | 12. CITIZEN OF WHAT COUNTRY U S A | |
| 13a. FATHER'S NAME Reuben Fouts | | 13b. MOTHER'S MAIDEN NAME Nellie M. Shipley | | 14. NAME OF HUSBAND OR WIFE None | | | |
| 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. 488-22-7359 | | 17. INFORMANT Mrs. Wilbur F. Moore | | Address 1328 No. 12th 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) Cerebral Hemorrhage | | | | | | INTERVAL BETWEEN ONSET AND DEATH at once | |
| 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 Month, Day, Year a.m. p.m. | | | | | | | |
| 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 6/26/57 to 1/1/60 and last saw her ^{her} _{him} alive on 12/31/59 | | | | Death occurred at 6:30 A.m. on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) S.E. Melaney M.D. | | | 22b. ADDRESS Social Welfare Board 10th & Olive, St. Joseph, Mo. | | | 22c. DATE SIGNED 1/2/60 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE Jan. 4, 1960 | 23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery | | 23d. LOCATION (City, town, or county) St. Joseph Missouri | | | |
| 24. FUNERAL DIRECTOR Honey Funeral Home NTE | | ADDRESS St. Joseph, Mo. | | 25. DATE RECD. BY LOCAL REG. Jan. 7, 1960 | 26. REGISTRAR'S SIGNATURE Mrs. Clark Toddell | | |

DOCUMENT

S. E. Melaney 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
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 conform 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.