

I DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-000331

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STATE FILE NUMBER

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

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u> Length of stay in 1b <u>life</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>309 S. 19th St.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Buchanan</u> c. CITY OR TOWN <u>St. Joseph</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>309 S. 19th St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>HELEN</u> Middle <u>MARTHA</u> Last <u>HEATON</u>			4. DATE OF DEATH Month <u>February</u> Day <u>3</u> Year <u>1960</u>				
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11/28/1912</u>	9. AGE (last birthday) <u>47</u>	IF UNDER 1 YEAR Months _____ Days _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>St. Joseph, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>Percy E. Heaton</u>		13b. MOTHER'S MAIDEN NAME <u>Nora J. Rasmussen</u>		14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT Address <u>Miss Loraine Heaton, 309 S. 19th, St. Joseph, Mo.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>generalized metastasis</u> DUE TO (b) <u>breast carcinoma</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 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					INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>		
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 _____ s.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 <u>10 Sept. 1958</u> to <u>death</u> and last saw her alive on <u>31 Jan. 1960</u> Death occurred at <u>1:40 p.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			22a. SIGNATURE (Degree or title) <u>Kandal Weed, M.D.</u>				
22b. ADDRESS <u>702 Jules St., Saint Joseph, Missouri</u>		22c. DATE SIGNED <u>2-3-60</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>			
23b. DATE <u>2/6/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ashland Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>St. Joseph Missouri</u>				
24. FUNERAL DIRECTOR ADDRESS <u>Heaton - Bowman St. Joseph, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Feb. 9, 1960</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Clark Standell</u>				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

R. Weed, M.D.

Dr. Fisher

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 *William J. [unclear]*

Licensed Embalmer No. *4535*

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.