

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-000430

FILED VS. JAN 25 1960

042

Primary Registration District No. 1000

Registrar's No. 72

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>54 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>State Hospital # 2</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <i>6024 Pryor Ave.</i>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>PEARL</i> Middle <i>M.</i> Last <i>WYNNE</i>			4. DATE OF DEATH Month <i>January</i> Day <i>17</i> Year <i>1960</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>May 7, 1886</i>	9. AGE (last birthday) <i>73</i>	IF UNDER 1 YEAR Months _____ Days _____
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>own home</i>	11. BIRTHPLACE (City and state or country) <i>Stanberry, Missouri</i>	12. CITIZEN OF WHAT COUNTRY <i>USA</i>		
13a. FATHER'S NAME <i>James Stephenson</i>		13b. MOTHER'S MAIDEN NAME <i>Emely Perkins</i>		14. NAME OF HUSBAND OR WIFE <i>Forrest F. Wynne</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, <i>no</i> unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>none</i>	17. INFORMANT Address <i>Forrest F. Wynne 6024 Pryor Ave.</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>Myocardial Infarction</i>					INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) <i>Chronic Myocarditis</i>					
DUE TO (c) <i>Generalized Arteriosclerosis</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Chronic Brain Syndrome Associated with Cerebral Arteriosclerosis</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>Jan. 16, 1960</i> <i>Jan. 17, 1960</i> and last saw ^{her} _{him} alive on <i>Jan. 17, 1960</i>	Death occurred at <i>12:25</i> <i>a</i> m on the date stated above, and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE (Degree or title) <i>G. E. Cassard M.D.</i>			22b. ADDRESS <i>State Hospital # 2 St. Joseph, Mo</i>		22c. DATE SIGNED <i>1/17/60</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>Jan. 19, 1960</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Memorial Park Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>St. Joseph, Mo.</i>		
24. FUNERAL DIRECTOR ADDRESS <i>Clark Funeral Home St. Joseph, Mo.</i>		25. DATE RECD. BY LOCAL REG. <i>Jan. 19, 1960</i>	26. REGISTRAR'S SIGNATURE <i>Mr. Clark Goodell</i>		

DOCUMENT

MEDICAL CERTIFICATION

C. E. Cassins, 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 Emil A. Clark

Licensed Embalmer No. 4238

P. O. Address Spring

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.