

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-005193

FILED VS. FEB 23 1960
 DEED

042

1000

211

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 Missouri COUNTY Atchison									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in 1b 10 Yrs		c. CITY OR TOWN Rockport		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hospital # 2			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) Unknown		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First ELLA Middle _____ Last EMERY				4. DATE OF DEATH Month February Day 16, Year 1960									
5. SEX Female		6. COLOR OR RACE White		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 1974		9. AGE (last birthday) 86		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (City and state or country) Unknown		12. CITIZEN OF WHAT COUNTRY USA						
13a. FATHER'S NAME Unknown				13b. MOTHER'S MAIDEN NAME Unknown				14. NAME OF HUSBAND OR WIFE Unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Virgil Clement Address Westboro, 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) Hypostatic Broncho Pneumonia										INTERVAL BETWEEN ONSET AND DEATH 2 Days			
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) Generalized and Cerebral Arteriosclerosis								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 Feb. 16, 1960 to Feb. 16, 1960 and last saw her/him alive on Feb. 16, 1960 Death occurred at 3:40 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) Mary B. Ames, M.D.						22b. ADDRESS St. Joseph, Mo.				22c. DATE SIGNED 2/16/60			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 2-16-60		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town, or county) (State) Westboro, Mo.						
24. FUNERAL DIRECTOR H.O. Sidenfaden & Son ADDRESS St Joseph, Mo.				25. DATE RECD. BY LOCAL REG. Feb. 16, 1960		26. REGISTRAR'S SIGNATURE Mrs Clark Goodell							

DOCUMENT

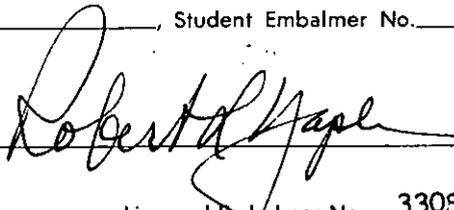
MEDICAL CERTIFICATION
 M.B. Ames, M.D.

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  _____

Licensed Embalmer No. 3308

P. O. Address St. Joseph, Mo.

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.