

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-005212

FILED VS. FEB 23 1960

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 188

STATE FILE NUMBER

| | | | | | | | | | |
|--|---|---|--|--|--|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Buchanan</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Buchanan</u> | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u> | | Length of stay in lb <u>Life</u> | | c. CITY OR TOWN <u>Rushville</u> | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph's Hospital</u> | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <u>Wayne Twsp.</u> | | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>OPAL</u> Middle <u>GRACE</u> Last <u>HOOK</u> | | | | 4. DATE OF DEATH Month <u>February</u> Day <u>4</u> Year <u>1960</u> | | | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH <u>2-4-1899</u> | 9. AGE (last birthday) <u>61</u> | 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) <u>Housewife</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | | 11. BIRTHPLACE (City and state or country) <u>Cleveland, Missouri</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | | |
| 13a. FATHER'S NAME <u>Joseph Fry</u> | | | 13b. MOTHER'S MAIDEN NAME <u>Elsie Noyes</u> | | | 14. NAME OF HUSBAND OR WIFE <u>William Hook</u> | | | |
| 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>None</u> | | 17. INFORMANT Address <u>William Hook, Rt # 2 Rushville</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>Cerebral vascular accident</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>6 da</u> | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | DUE TO (b) <u>Hypertension, Renal.</u> | | | DUE TO (c) <u>yes</u> | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Obesity</u> | | | | | 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 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 <u>Jan 60</u> to <u>2-4-60</u> and last saw her <u>born</u> alive on <u>2-4-60</u> . Death occurred at <u>1:30 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | |
| 22a. SIGNATURE (Degree or title) <u>M.E. Grimes M.D.</u> | | | | 22b. ADDRESS <u>St Joseph Mo</u> | | | 22c. DATE SIGNED <u>2-8-60</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE <u>2-6-1960</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Westlawn Cemetery</u> | | | 23d. LOCATION (City, town, or county) (State) <u>De Kalb, Missouri</u> | | | | |
| 24. FUNERAL DIRECTOR ADDRESS <u>St. Joseph, Mo.</u> | | | 25. DATE RECD. BY LOCAL REG. <u>Feb. 15, 1960</u> | | 26. REGISTRAR'S SIGNATURE <u>Mrs. Clark Goodell</u> | | | | |

DOCUMENT

BY AFFIDAVIT OF M.E. Grimes, M.D. MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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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

only _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed John E. Kepp

Licensed Embalmer No. 3986

P. O. Address St. Joseph

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.