

1 DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-005215

FILED VS MAR 14 1960

042

1000

300

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Buchanan</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>		Length of stay in 1b <b>1 day</b>		c. CITY OR TOWN <b>Faucett</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>D.O.A. St. Josephs Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>WALTER</b> Middle <b>S.</b> Last <b>HULL</b>				4. DATE OF DEATH Month <b>March</b> Day <b>8,</b> Year <b>1960</b>					
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>3/26/1873</b>	9. AGE (last birthday) <b>86</b>	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) <b>Physician</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>New Market, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>		
13a. FATHER'S NAME <b>Walter S. Hull</b>			13b. MOTHER'S MAIDEN NAME <b>Susan B. Lowe</b>			14. NAME OF HUSBAND OR WIFE <b>Victoria B. Hull</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT Address <b>J. P. Hull, 2207 Felix St., St. Joseph, Mo.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>presumed acute coronary occlusion (history of previous occlusion)</b>								INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>	
DUE TO (b) <b>arteriosclerotic heart disease</b>								<b>several years</b>	
DUE TO (c) <b>generalized arteriosclerosis</b>								<b>several years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>post-resection prostatic hypertrophy, Cystitis, osteomyelitis, osteoarthritis</b>								PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N. <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 _____		<b>(patient was pronounced dead on arrival at hospital by me - coroner notified - but released case. No injury.)</b>							
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 <b>1-10-'59</b> to <b>2-5-'59</b> and last saw <sup>her</sup> him alive on <b>2-5-'59</b> Death occurred at <b>10 30</b> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <b>Thompson C. Potter, M.D.</b>				22b. ADDRESS <b>731 Forum St St. Joseph, Mo.</b>			22c. DATE SIGNED <b>3-9-60</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>3/10/1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Faucett Cemetery</b>			23d. LOCATION (City, town, or county) (State) <b>Faucett Missouri</b>			
24. FUNERAL DIRECTOR <b>Helen Bowman</b>			ADDRESS <b>St. Joseph, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>Mar. 11, 1960</b>		26. REGISTRAR'S SIGNATURE <b>Mrs. Clark Goodell</b>		

DOCUMENT

MEDICAL CERTIFICATION  
T.E. Potter, 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 Ernest Wood

Licensed Embalmer No. 3804  
P. O. Address 319 So 10th

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.