...URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

-60-005244

STATE FILE NUMBER

FILED VS MAR 14 1960

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 293

...MENDED

1. PLACE OF DEATH
a. COUNTY Buchanan
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph — Length of stay in 1b 2weeks
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Methodist Hosp. — Inside Limits Yes [X] No [ ]

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo b. COUNTY Buchanaan
c. CITY OR TOWN Faucett — Inside Limits Yes [ ] No [X]
d. STREET ADDRESS (If outside, give location) General Del — Reside on Farm Yes [X] No [ ]

3. NAME OF DECEASED (Type or print) First Gus Middle Noah Last
4. DATE OF DEATH Month March Day 1, Year 1960

5. SEX Male
6. COLOR OR RACE White
7. Married [ ] Never Married [ ] Widowed [X] Divorced [ ]
8. DATE OF BIRTH April 12, 1884
9. AGE (last birthday) 75 — 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) Re. Laborer
10b. KIND OF BUSINESS OR INDUSTRY Armour & Co
11. BIRTHPLACE (City and state or country) Worth Co, Iowa
12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME Joaeph, J. Noah
13b. MOTHER'S MAIDEN NAME Margaret Hogan
14. NAME OF HUSBAND OR WIFE deceased

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. 487-09-1202
17. INFORMANT Marie Larson Address Faucett 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) Bronchial Pneumonia — INTERVAL BETWEEN ONSET AND DEATH 1wk
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Cardiac Decompensation — 1yr.
DUE TO (c) Arterio-sclerotic cardiovascular disease
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. [ ] Yes [X] No [ ] Unknown

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]
20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
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 [ ] NOT WHILE AT WORK [ ]
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 1955, to Mar. 1,1960 and last saw her him alive on Feb.29,1960
Death occurred at 1:40 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) C.S. Grant MD
22b. ADDRESS St. Joseph Mo
22c. DATE SIGNED 3.6.60

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 3/4/60
23c. NAME OF CEMETERY OR CREMATORY Odd Fellows Public Cemetery
23d. LOCATION (City, town, or county) (State) St. Joseph, Mo

24. FUNERAL DIRECTOR John C. Rupp ADDRESS St. Joseph, Mo
25. DATE RECD. BY LOCAL REG. Mar. 9, 1960
26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF DOCUMENT

MEDICAL CERTIFICATION

C.S. Grant M.D.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

OF ZOW _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed John E. Rupp

Signature of Student Embalmer

Licensed Embalmer No. 3984

P. O. Address St. Joseph

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co 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.