

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-009987

FILED VS MAR 21 1960

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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 b. COUNTY Grundy				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in 1b 2 weeks		c. CITY OR TOWN Spickard		Inside Limits Yes <input type="checkbox"/> No <input checked="" 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) Franklin Township		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lester Middle Claude Last Marrs				4. DATE OF DEATH Month March Day 2, Year 1960				
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH Dec. 18, 1887	9. AGE (last birthday) 72	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Agriculture		11. BIRTHPLACE (City and state or country) Grundy Co., Mo.		12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME George Marrs			13b. MOTHER'S MAIDEN NAME Eliza Flowers			14. NAME OF HUSBAND OR WIFE Susie Marrs		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 493-18-8648 none		17. INFORMANT Address Mrs. Susie Marrs Spickard, 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) Cardiac failure DUE TO (b) Bronchopneumonia DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 24 hours 2 weeks		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Cerebral Arteriosclerosis						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 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 Month, Day, Year a.m. p.m.								
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 Mar. 2, 1960 to Mar. 2, 1960 and last saw her last saw him alive on Mar. 2, 1960 Death occurred at 11:30 A. m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) Mohammad Tahir M.D.				22b. ADDRESS State Hospital #2, St. Joseph, Mo.		22c. DATE SIGNED Mar. 2, 1960		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Mar. 4, 1960	23c. NAME OF CEMETERY OR CREMATORY Masonic Cemetery		23d. LOCATION (City, town, or county) (State) Spickard, Missouri.				
24. FUNERAL DIRECTOR Crescent Funeral Home St. Joseph, Mo.			25. DATE RECD. BY LOCAL REG. Mar. 11, 1960		26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell			

DOCUMENT

M. Tahir, M.D. MEDICAL CERTIFICATION

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 Albert B. Hawkins

Licensed Embalmer No. 435

P. O. Address St. Louis

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.