

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-009996

FILED VS APR 11 1960

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STATE FILE NUMBER

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

ENDED

1. PLACE OF DEATH a. COUNTY Buchanan			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in 1b 55 Years	c. CITY OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 517 South 17th St.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 517 South 17th St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Anna Alice Newby			4. DATE OF DEATH Month Day Year March 28, 1960			
5. SEX Female	6. COLOR OR RACE Negro	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH June 11, 1876	9. AGE (last birthday) 83	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Weston, Missouri		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME John Bruce		13b. MOTHER'S MAIDEN NAME Liza ?		14. NAME OF HUSBAND OR WIFE Silas H. Newby		
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. Unknown	17. INFORMANT Dodge City, Kans. Mrs Susie L. Wright, 1505-5th Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of the Parotid Gland					INTERVAL BETWEEN ONSET AND DEATH Unk.	
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)				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 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 3/14/60 to 3/28/60 and last saw her alive on 3/27/60 Death occurred at 7:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) S. M. Melaney M.D.			22b. ADDRESS Social Welfare Board 10th & Olive, St. Joseph, Mo.		22c. DATE SIGNED 3/29/60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Apr. 1, 1960	23c. NAME OF CEMETERY OR CREMATORY Ashland, Cemetery		23d. LOCATION (City, town, or county) (State) St. Joseph, Missouri		
24. FUNERAL DIRECTOR Wm. H. Alexander		ADDRESS St. Joseph, Mo.	25. DATE RECD. BY LOCAL REG. April 1, 1960	26. REGISTRAR'S SIGNATURE Wm. Clark Goodell		

DOCUMENT

S.E. Melaney, 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 me  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Wm. H. Alexander

Licensed Embalmer No. 4450

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.