

# FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**60-010027**

FILED VS APR 11 1960 042

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STATE FILE NUMBER

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

<b>1. PLACE OF DEATH</b> a. 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>16 Yrs</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>  c. CITY OR TOWN <b>Kansas City</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <b>3030 McGee</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>State Hospital No. 2</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			

<b>3. NAME OF DECEASED</b> (Type or print) First <b>CORINDA</b> Middle _____ Last <b>TAYLOR</b>			<b>4. DATE OF DEATH</b> Month <b>April</b> Day <b>4,</b> Year <b>1960</b>			
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input checked="" type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>5-26-1901</b>	<b>9. AGE (last birthday)</b> <b>58</b>	<b>IF UNDER 1 YEAR</b> Months _____ Days _____	<b>IF UNDER 24 HR</b> Hours _____ Min. _____

<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Cleaner-Presser</b>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Laundry</b>	<b>11. BIRTHPLACE</b> (City and state or country) <b>North Bend, Indiana</b>	<b>12. CITIZEN OF WHAT COUNTRY</b> <b>USA</b>
<b>13a. FATHER'S NAME</b> <b>Harris Maxwell</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>Molly McManis</b>	
<b>14. NAME OF HUSBAND OR WIFE</b> <b>Everett</b>			

<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	<b>16. SOCIAL SECURITY NO.</b> <b>None</b>	<b>17. INFORMANT</b> Address <b>State Hospital # 2 Records St. Joseph, Mo</b>	
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<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Failure (Coronary Thrombosis)</b> DUE TO (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>Indefinite</b>
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 type="checkbox"/> No <input type="checkbox"/> Unknown

<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)	
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____			

<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b>	<b>COUNTY</b> _____ <b>STATE</b> _____
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21. I attended the deceased from **April 4, 1960** to **April 4, 1960** and last saw her **alive** on **April 4, 1960** at **6:20 a.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

<b>22a. SIGNATURE</b> (Degree or title) <i>Mohammad Tahir M.D.</i>		<b>22b. ADDRESS</b> <b>State Hospital # 2 St. Joseph, Mo.</b>		<b>22c. DATE SIGNED</b> <b>4-4-60</b>
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>	<b>23b. DATE</b> <b>Apr. 6, 1960</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Mt. Olivet Cemetery</b>	<b>23d. LOCATION (City, town, or county) (State)</b> <b>St. Joseph, Mo.</b>	
<b>24. FUNERAL DIRECTOR</b> ADDRESS <i>H.O. Sidunfady &amp; Son St. Joseph, Mo</i>		<b>25. DATE RECD. BY LOCAL REG.</b> <b>April 5, 1960</b>		<b>26. REGISTRAR'S SIGNATURE</b> <i>Mrs. Clark Gardell</i>

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

M. Tahir, M.D.

R.P. 4.

**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 Robert H. Gaper  
Licensed Embalmer No. 3308

P. O. Address St. Joseph, Mo.

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