

REGISTRATION DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-014220

FILED VS MAY 9 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 Buchanan				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in 1b 9 days		c. CITY OR TOWN Agency		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Methodist Hosp.			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 Middle Last NANCY PRISCILLA BABCOCK				4. DATE OF DEATH Month Day Year April 24, 1960				
5. SEX female	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 12/7/1892	9. AGE (last birthday) 67		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) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (City and state or country) Agency Missouri		12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME Joseph Deatherage			13b. MOTHER'S MAIDEN NAME Louisa Reynolds			14. NAME OF HUSBAND OR WIFE Roy Babcock		
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. none		17. INFORMANT Address Roy Babcock, Agency, 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) Cerebral-vascular accident							INTERVAL BETWEEN ONSET AND DEATH 9 days	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) Hypertensive arterio sclerotic cardio-vascular disease.						
		DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Diabetes Mellitus						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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.		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)						
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. CITY, TOWN, OR LOCATION		20f. COUNTY		STATE		
21. I attended the deceased from Aug. 1955 to Apr. 24, '60 and last saw her ^{her} him alive on Apr 23, 1960 Death occurred at 7:00 a. 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 M.D.				22b. ADDRESS St. Joseph, Mo.		22c. DATE SIGNED 5-3-60		
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 4/26/1960	23c. NAME OF CEMETERY OR CREMATORY Agency Cemetery		23d. LOCATION (City, town, or county) (State) Agency Missouri			
24. FUNERAL DIRECTOR ADDRESS Henton-Bowman, St. Joseph, Mo.			25. DATE RECD. BY LOCAL REG. May 6, 1960		26. REGISTRAR'S SIGNATURE Wes. Clark Goodell			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

C.S. Grant!

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 William Spalding

Licensed Embalmer No. 4525

P. O. Address St. Joseph, Mo.

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.