

R DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-014251

FILED VS APR 18 1960 042

Registration District No. _____ Primary Registration District No. **1000** Registrar's No. **445**

STATE FILE NUMBER

DED

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 Life		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 2747 Penn St.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 2747 Penn St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First MARY Middle S. Last EAGAN				4. DATE OF DEATH Month April Day 8, Year 1960									
5. SEX Female		6. COLOR OR RACE White		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 12-3-1881		9. AGE (last birthday) 78		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) Ret. (5) Secy. & Partner				10b. KIND OF BUSINESS OR INDUSTRY Insurance Agency		11. BIRTHPLACE (City and state or country) St. Joseph, Mo.		12. CITIZEN OF WHAT COUNTRY USA					
13a. FATHER'S NAME John Eagan				13b. MOTHER'S MAIDEN NAME Mary Ann McCormick				14. NAME OF HUSBAND OR WIFE None					
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. 500-34-7379		17. INFORMANT Address Catherine G. Eagan 2747 Penn City							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Coronary arteriosclerosis DUE TO (c) Generalized arteriosclerosis										INTERVAL BETWEEN ONSET AND DEATH about a year & several years.			
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					
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. _____		Month, Day, Year											
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 1954 to 4-8-60 and last saw ^(her) _(him) live on 4-7-60 Death occurred at 10:25 A m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) Lucien H. Ide M.D.						22b. ADDRESS 902 Central St. Joseph				22c. DATE SIGNED 4-9-60			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Apr. 11, 1960		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town, or county) (State) St. Joseph, Mo.							
24. FUNERAL DIRECTOR ADDRESS H.O. Sidenfaden & Son St. Joseph, Mo.				25. DATE RECD. BY LOCAL REG. April 13, 1960		26. REGISTRAR'S SIGNATURE Wm. Clark Standell							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

L.W. Ide, M.D.

R.X. 4.

(Licensed Embalmer's Statement on Reverse Side)

Dr. J. L.

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. Gable* _____

Licensed Embalmer No. 3303

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.