

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-014265

FILED VS. APR 18 1960 042

Primary Registration District No. 1000 Registrar's No. 454

STATE FILE NUMBER

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		c. CITY OR TOWN St. Joseph	
Length of stay in 1b Lifetime		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 604 Lincoln St.,		d. STREET ADDRESS (If outside, give location) 604 Lincoln St.,	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First George Middle S. Last Haskey			4. DATE OF DEATH Month April Day 8, 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 Sep. 8, 1900	9. AGE (last birthday) 59	IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HR Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman		10b. KIND OF BUSINESS OR INDUSTRY City Fire Dept.		11. BIRTHPLACE (City and state or country) St. Joseph, Missouri		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Stephen Haskey			13b. MOTHER'S MAIDEN NAME Rose Rosendowski		14. NAME OF HUSBAND OR WIFE Edna Haskey		

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. 486-30-2449	17. INFORMANT Mrs. Edna Haskey, St. Joseph, Missouri
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) VENTRICULAR FIBRILLATION		7 MIN
DUE TO (b) AORTIC STENOSIS		CONGENITAL
DUE TO (c) CHRONIC CONGESTIVE FAILURE		59 YRS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		3 MOS.
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 6:00 Month, Day, Year 10/21/1957	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 St. Joseph, Missouri		20g. COUNTY Missouri STATE Missouri

21. I attended the deceased from 10/21/1957 to 4/18/1960 and last saw him alive on 4/15/60 . Death occurred at 6:00 P. on the date stated above, and to the best of my knowledge, from the causes stated.		
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22a. SIGNATURE (Degree or title) J.T. Rogers M.D.		22b. ADDRESS 307 Karpatevich St. St. Joseph Mo		22c. DATE SIGNED 4/11/60
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, Missouri	

24. FUNERAL DIRECTOR Mrs. Clark Goodell	ADDRESS St. Joseph, Mo.	25. DATE RECD. BY LOCAL REG. April 15, 1960	26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

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 *Eric J. Murray*

Licensed Embalmer No. 4679

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.