

R DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAY 9 1960

-60-014284

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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	c. CITY OR TOWN Easton
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Swisher Nursing Home 214 Texas St.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) None
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) JOHN	First	Middle P.	Last LARKIN Sr.	4. DATE OF DEATH Month April Day 29, Year 1960
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5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8-12-1883	9. AGE (last birthday) 76	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. (10) Grocer	10b. KIND OF BUSINESS OR INDUSTRY Retail Grocery	11. BIRTHPLACE (City and state or country) Conway, Mo.	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME John J. Larkin	13b. MOTHER'S MAIDEN NAME Bridgett Gibbons	14. NAME OF HUSBAND OR WIFE Nellie C.
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give way or dates of service) Yes W.W.# 1	16. SOCIAL SECURITY NO.	17. INFORMANT Address Paul F. Larkin St. Joseph, Mo.
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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 about 5 days
IMMEDIATE CAUSE (a)	Cerebral Vascular Accident	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	Arteriosclerosis, generalized	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Bronchopneumonia, terminal		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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year
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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, Mo	COUNTY	STATE
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21. I attended the deceased from **2/24/60** to **4/29/60** and last saw her/him alive on **4/25/60**
Death occurred at **4:30 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Wm Redwood MD</i> (Degree or title)	22b. ADDRESS St Joseph, Mo	22c. DATE SIGNED 4/30/60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5-2-60	23c. NAME OF CEMETERY OR CREMATORY St. Joseph's Cemetery	23d. LOCATION (City, town, or county) Easton, Mo.
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24. FUNERAL DIRECTOR H.O. Sidenfaden & Son	ADDRESS St Joseph, Mo.	25. DATE RECD. BY LOCAL REG. May 1, 1960	26. REGISTRAR'S SIGNATURE <i>Mrs. Clark Goodell</i>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

Wm Redwood, 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
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 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.