

**1 DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**FILED VS MAY 2 1960** 042

**=60-014325**

Registration District No. \_\_\_\_\_ Primary Registration District No. 1000 Registrar's No. 508

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clinton</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>		Length of stay in 1b <u>35 years</u>	c. CITY OR TOWN <u>Plattsburg</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital#2</u>		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 <u>JESS</u> Middle <u>SPEED</u> Last <u>TRANSUE</u>			4. DATE OF DEATH Month <u>April</u> Day <u>26</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4-5-1888</u>	9. AGE (last birthday) <u>72</u>	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) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (City and state or country) <u>Clay County, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Francis Marion Transue</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth E. Fry</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT Address <u>State Hospital#2, St. Joseph, Mo</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Liver</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____						
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 <u>April 21, 1960</u> to <u>April 26, 1960</u> and last saw her/him alive on <u>April 25, 1960</u> Death occurred at <u>6:50</u> <u>a</u> m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <u>Mohammed T. Ahmad</u>			22b. ADDRESS <u>State hospital#2, St. Joseph</u>		22c. DATE SIGNED <u>4-26-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>4-27-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Brethern Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Plattsburg, Missouri</u>			
24. FUNERAL DIRECTOR ADDRESS <u>Lyon Funeral Home Inc. Plattsburg Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>April 27, 1960</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Clark Standell</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

M. Tahir, M.D.

**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

*Phillip E. Cook*

Licensed Embalmer No. 4093

P. O. Address Stausburg

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.