

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-022377

FILED JUL 11 1960

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 720 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>Buchanan</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>		Length of stay in 1b <u>Lifetime</u>	c. CITY OR TOWN <u>St. Joseph</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>D.O.A. Mo. Methodist Hosp.</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1206 Frederick Ave.,</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Glen</u> Middle <u>F.</u> Last <u>House</u>			4. DATE OF DEATH Month <u>June</u> Day <u>27</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 type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 12, 1903</u>	9. AGE (last birthday) <u>56</u>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Quaker Oats Co.</u>	11. BIRTHPLACE (City and state or country) <u>St. Joseph, Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>John H. House</u>		13b. MOTHER'S MAIDEN NAME <u>Cassia Savannah Carder</u>		14. NAME OF HUSBAND OR WIFE <u>Grace Belle House</u>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>715-07-0239</u>	17. INFORMANT <u>Bessie P. Yeakley, St. Joseph, Missouri</u>
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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: IMMEDIATE CAUSE (a) <u>Unattended Death - Natural Causes</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last: <u>Investigated by City Health Dept</u> DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH
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 _____ to _____ and last saw her/him alive on _____.
Death occurred at 5:45 P. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE OF REGISTRAR (Degree or title) <u>Robert Walker, M.D. (C.H.O.)</u>	22b. ADDRESS <u>St Joseph, Mo</u>	22c. DATE SIGNED <u>6-29-60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>June 29, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>
24. FUNERAL DIRECTOR <u>Aschoff-Herman Inc. St. Joseph, Mo.</u>		23d. LOCATION (City, town, or county) (State) <u>St. Joseph, Missouri</u>
25. DATE RECD. BY LOCAL REG. <u>July 4, 1960</u>		26. REGISTRAR'S SIGNATURE <u>Mr. Clark Goodell</u>

DOCUMENT BY AFFIDAVIT OF R.W. Kieber, M.D. MEDICAL CERTIFICATION

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. Channing*
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 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.