

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-022380

FILED VS JUN 20 1960 042

Registration District No. Primary Registration District No. 1000 Registrar's No. 652

STATE FILE NUMBER

NDED

|   |   |   |   |   |   |  |
|---|---|---|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Buchanan</b>  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Mo</b> b. COUNTY <b>Buchanan</b> |   |   |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>St. Joseph</b>  |   | Length of stay in 1b<br><b>25yrs</b>  | c. CITY OR TOWN <b>St. Joseph</b>   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |  |
| c. FULL NAME OF (IF NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>2414 1/2 Bartlett</b>   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location)<br><b>2414 1/2 Bartlett</b>   |   | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>ROSA</b> Middle <b>HUGHES</b> Last   |   |   | 4. DATE OF DEATH<br>Month <b>June</b> Day <b>7</b> Year <b>1960</b>   |   |   |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>  | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>June 20, 1888</b>  | 9. AGE (last birthday)<br><b>71</b>   | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer (re)</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Cafe</b>  | 11. BIRTHPLACE (City and state or country)<br><b>K.C. Kansas</b>  | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>  |   |  |
| 13a. FATHER'S NAME<br><b>Henry Falk</b>   |   | 13b. MOTHER'S MAIDEN NAME<br><b>Clara Geising</b>   |   | 14. NAME OF HUSBAND OR WIFE<br><b>Eddie Hughes (de)</b>   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>no</b>  |   | 16. SOCIAL SECURITY NO.<br><b>491-22-5641</b>   | 17. INFORMANT Address<br><b>Otto Priemer K.C? Kansas</b>  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b>   |   |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>immediate</b>                                  |  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <b>Arteriosclerotic Heart Disease</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.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour Month, Day, Year<br>a.m. p.m.   |   |   |   |   |   |  |
| 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 <b>Aug. 1955</b> to <b>June 7, 1960</b> and last saw her alive on <b>Jan 13, 1960</b><br>Death occurred at <b>9:30 a.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated. |   |   |   |   |   |  |
| 22a. SIGNATURE (Degree or title)<br><b>Martin A. Christ MD</b>  |   |   | 22b. ADDRESS<br><b>4106 King Hill Ave</b>   |   | 22c. DATE SIGNED<br><b>June 7, 1960</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE<br><b>6/9/60</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Odd Fellows Public Cemetery</b>  |   | 23d. LOCATION (City, town, or county) (State)<br><b>St. Joseph, Mo</b>  |   |  |
| 24. FUNERAL DIRECTOR<br><b>John E. Rupp</b>   | ADDRESS<br><b>St. Joseph, Mo</b>  | 25. DATE RECD. BY LOCAL REG.<br><b>June 10, 1960</b>  | 26. REGISTRAR'S SIGNATURE<br><b>Mrs. Clark Hardell</b>  |   |   |  |

DOCUMENT

MEDICAL CERTIFICATION

M.A. Christ, MD

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

*John E. Rupp*

Licensed Embalmer No. 3986

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.