

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-029675

FILED VS AUG 29 1960

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STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

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 lb <u>62 Yrs</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>Missouri Methodist Hosp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>3001 Felix Street</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>Ruth</u> Last <u>Betts</u>			4. DATE OF DEATH Month <u>August</u> Day <u>21</u> Year <u>1960</u>	
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>June 7, 1898</u>	9. AGE (last birthday) <u>62</u>	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) <u>Factory worker</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Noma Lites Factory</u>	11. BIRTHPLACE (City and state or country) <u>St. Joseph, Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>Albert Eddins</u>	13b. MOTHER'S MAIDEN NAME <u>Anna Tymon</u>	14. NAME OF HUSBAND OR WIFE <u>Thomas R. Betts</u>
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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>491-28-0766</u>	17. INFORMANT (sister) <u>Gertrude Necum</u> Address <u>St. Joseph, Mo.</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>Pulmonary Heart Disease & Cardiac Failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Chronic Bronchial Asthma</u>	
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"/> N. <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 _____	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
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21. I attended the deceased from <u>8-19-60</u> to <u>8-21-60</u> and last saw her alive on <u>8-21-60</u> Death occurred at <u>7:30 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>H. C. Semme MD</u> (Degree or title)	22b. ADDRESS <u>223 W 7th St. Joseph Mo</u>	22c. DATE SIGNED <u>8-24-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Aug. 23, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Vernon Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Atchison, Kansas</u>
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24. FUNERAL DIRECTOR <u>Miss Elmer St Joseph Mo</u> <u>R.H.</u>	25. DATE RECD. BY LOCAL REG. <u>Aug 26, 1960</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Clark Handell</u>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF H. C. Semme, M.D. MEDICAL CERTIFICATION

OCT 10 1962

MAR 29 1963

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 [Handwritten Signature]

Licensed Embalmer No. 467

P. O. Address [Handwritten Address]

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.