

# JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 29 1960

042

Primary Registration District No.

1000

Registrar's No.

900

60-029626

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <i>Buchanan</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Daviess</i>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Joseph</i>		Length of stay in 1b <i>27 days</i>		c. CITY OR TOWN <i>Gallatin</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>State Hospital #2</i>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <i>Box 304</i>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>ETHEL</i> Middle <i>ELIZABETH</i> Last <i>BLACK</i>				4. DATE OF DEATH Month <i>August</i> Day <i>24</i> Year <i>1960</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <i>12/12/1885</i>	9. AGE (last birthday) <i>74</i>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <i>Gallatin, Mo.</i>	12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13a. FATHER'S NAME <i>Allen Graham</i>			13b. MOTHER'S MAIDEN NAME <i>Eunice Koger</i>		14. NAME OF HUSBAND OR WIFE <i>Robert N. Black</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT Address <i>Records, State Hosp. #2, St. Joseph, Mo.</i>			
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	
IMMEDIATE CAUSE (a) <i>Coronary Artery Disease</i>						<i>Unknown</i>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Hypostatic Pneumonia</i>						<i>2 weeks</i>	
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 Month, Day, Year 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 <i>8-24-1960</i> to <i>8-24-1960</i> and last saw her alive on <i>8-24-1960</i> Death occurred at <i>11:20 AM</i> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <i>Mohammad Ishaq M.D.</i>				22b. ADDRESS <i>State Hosp. #2, St. Joseph, Mo.</i>		22c. DATE SIGNED <i>8-24-60</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>Aug. 26, 1960</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Brown Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Gallatin, Mo.</i>			
24. FUNERAL DIRECTOR <i>Hope Funeral Home Gallatin, Mo</i>				25. DATE RECD. BY LOCAL REG. <i>Aug. 24, 1960</i>	26. REGISTRAR'S SIGNATURE <i>Mr. Clark Sandell</i>		

DOCUMENT

MEDICAL CERTIFICATION

M. Tahir, M.D.

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 me  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Alvin E. Began

Licensed Embalmer No. 4795

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.