

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-029707

FILED VS. SEP 12 1960

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STATE FILE NUMBER

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

1. PLACE OF DEATH a. COUNTY Buchanan				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in lb 4 years.		c. CITY OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 6524 Washington St.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 6524 Washington St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lue Middle Evaline Last Harper				4. DATE OF DEATH Month September Day 5, Year 1960				
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH Nov. 2, 1887	9. AGE (last birthday) 72	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) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (City and state or country) Gentry Co, Missouri.		12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME Charles Fisher			13b. MOTHER'S MAIDEN NAME Mary Margaret Smith		14. NAME OF HUSBAND OR WIFE Marion F. Harper			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. none		17. INFORMANT Loren Harper Address St. Joseph, Mo.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Hemorrhage						INTERVAL BETWEEN ONSET AND DEATH 2 days		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Generalized Arteriosclerosis						unk		
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"/> 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.)					
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 Sept 2, 1960 to Sept 5, 1960 and last saw her ^{her} _{him} alive on Sept 2, 1960 Death occurred at 6:30 P. on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) Martin H Christman				22b. ADDRESS 6106 King Hill Ave St Joseph Mo		22c. DATE SIGNED 9/7/60		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Sept. 6, 1960	23c. NAME OF CEMETERY OR CREMATORY Lock Springs Cemetery		23d. LOCATION (City, town, or county) (State) Lock Springs, Missouri.				
24. FUNERAL DIRECTOR Meierhoffer-Flesman ADDRESS St. Joseph, Mo.			25. DATE RECD. BY LOCAL REG. Sept. 8, 1960		26. REGISTRAR'S SIGNATURE Wm. Clark Stoddell			

DOCUMENT

M.H. Christman MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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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 Albert B. Harrington

Licensed Embalmer No. 3258

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.