

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. OCT 17 1960

042

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1053

-60-033863

STATE FILE NUMBER

NDED

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 1b 47 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 1310 Francis St.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1310 Francis		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle DANIEL Last DAWSON				4. DATE OF DEATH Month Oct. Day 7, Year 1960			
5. SEX male	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7/12/1864	9. AGE (last birthday) 96	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) proprietor		10b. KIND OF BUSINESS OR INDUSTRY Grocery Store		11. BIRTHPLACE (City and state or country) Decatur, Ind.		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Joseph H. Dawson		13b. MOTHER'S MAIDEN NAME Sarah E. Lough		14. NAME OF HUSBAND OR WIFE Beulah A.			
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. 497-14-4226		17. INFORMANT Address Beulah A. Dawson, 1310 Francis, 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) Hypostatic Pneumonia Conditions, if any, which gave rise to above cause (a), stating the underlying cause last: DUE TO (b) Prostatic Ca. + hypertrophy. DUE TO (c) several yrs. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hr.	
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 10/18/58 to 6/10/60 and last saw him alive on 10/7/60 Death occurred at 9:40 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE Wm. R. Litchcomb, D.O. (Degree or title)				22b. ADDRESS 314 N. 20th. St. Joseph, Mo		22c. DATE SIGNED 10/8/60	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 10/9/1960		23c. NAME OF CEMETERY OR CREMATORY Walnut Grove Cemetery		23d. LOCATION (City, town, or county) (State) Buchanan County, Mo.	
24. FUNERAL DIRECTOR Heaton-Bowman		ADDRESS St. Joseph, Mo.		25. DATE RECD. BY LOCAL REG. Oct. 11, 1960		26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell	

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

W.R. Litchcomb, D.O. MEDICAL CERTIFICATION

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 William Spalding

Licensed Embalmer No. 445-28

P. O. Address B. 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.