

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-033894

FILED VS OCT 3 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 1b 50 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 1517 S. 11th St.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1517 S. 11th St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle N. Last HOWARD				4. DATE OF DEATH Month September Day 18 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 12/23/1886	9. AGE (last birthday) 73	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) Retired truck driver		10b. KIND OF BUSINESS OR INDUSTRY Milling Company		11. BIRTHPLACE (City and state or country) Hiawatha, Kansas		12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME William Howard			13b. MOTHER'S MAIDEN NAME Laura Bell Slagley		14. NAME OF HUSBAND OR WIFE Hulda C. Howard			
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. 491-10-3056		17. INFORMANT Address Mrs. Hulda C. Howard, 1517 S. 11th, St. Joseph				
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 Hemorrhage DUE TO (b) sclerosis of cerebral vessels DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 10 days years		
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 _____ a.m. _____ p.m. Month Sept Day 8 Year 60	While returning from bathroom							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home		20f. CITY, TOWN, OR LOCATION St Joseph Buchanan Mo		COUNTY Buchanan		STATE Mo	
21. I attended the deceased from Sept 16 60 to Sept 18-60 and last saw her/him alive on Sept 17-60 Death occurred at 9:50 a. m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) S.E. Melaney M.D.				22b. ADDRESS 214 Kirkpatrick St. Joseph 81 Mo		22c. DATE SIGNED Sept 20 60		
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 9/21/1960	23c. NAME OF CEMETERY OR CREMATORY Ashland Cemetery		23d. LOCATION (City, town, or county) (State) St. Joseph Missouri				
24. FUNERAL DIRECTOR Heaton Bowman		ADDRESS St. Joseph, Mo.		25. DATE RECD. BY LOCAL REG. Sept 26, 1960	26. REGISTRAR'S SIGNATURE Peter Clark Gardell			

DOCUMENT

S.E. Melaney, M.D. 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. 4535

P. O. Address St Joseph, Mo

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.