

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-041082

FILED VS DEC 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 Euchanan				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 32 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 Mo. Meth. Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 802 N. 6th Street		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Pearl Middle Milleson Last Bryant				4. DATE OF DEATH Month December Day 2 Year 1960					
5. SEX Female	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 Apr. 22, 1904	9. AGE (last birthday) 56	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) Hardin, Missouri		12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME James Luther Foster			13b. MOTHER'S MAIDEN NAME Daisy Pelle Fields			14. NAME OF HUSBAND OR WIFE Raymond Bryant			
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. 493-38-7654		17. INFORMANT Raymond Bryant			Address St. Joseph, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (d). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYPOSTATIC PNEUMONIA							INTERVAL BETWEEN ONSET AND DEATH 2 DAYS		
DUE TO (b) RT. AND LT. VENTRICULAR FAILURE, CHRONIC							1 YR.		
DUE TO (c) ARTERIOSCLEROTIC HYPERTENSIVE CARDIOVASCULAR DISEASE							4 YRS.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) (a) DIABETES MELLITUS (b) ARTERIOSCLEROSIS OBLITERANS WITH NECROSIS RT. FOOT							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 2-9-60 to 12-2-60 and last saw her/him alive on 12-1-60 Death occurred at 8115 A. on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) R.L. Maginn M.D.				22b. ADDRESS P.O. BLDG 216, St. Joseph, Mo			22c. DATE SIGNED 12-3-60		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Dec. 5, 1960	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery		23d. LOCATION (City, town, or county) St. Joseph, Missouri		23e. (State)			
24. FUNERAL DIRECTOR Meierhoffer-Fleeman, Inc., St. Joseph, Mo.				25. DATE RECD. BY LOCAL REG. Dec. 7, 1960		26. REGISTRAR'S SIGNATURE John Clark Goodell			

DOCUMENT

R.L. Maginn, M.D. MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DEC 14 1960

DEC 12 1960

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. Harrison

Licensed Embalmer No. 3250

P. O. Address H. 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.