

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-041109

FILED VS NOV 21 1960

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 1183 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Platte</u>						
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>		Length of stay in 1b <u>9 m 19d</u>		c. CITY OR TOWN <u>Weston</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph Stake Hosp.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>712. Spring St</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Daisy</u> Middle <u>D.</u> Last <u>Howard</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>13</u> Year <u>1960</u>						
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>June 16, 1885</u>	9. AGE (last birthday) <u>75</u>	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) <u>housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (City and state or country) <u>Popular, Ky.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>			
13a. FATHER'S NAME <u>George H. Palatt</u>			13b. MOTHER'S MAIDEN NAME <u>Esther Ann Collins</u>		14. NAME OF HUSBAND OR WIFE <u>Jean S. Lney Howard</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Records of State Hospital, St. Joseph</u>		Address _____				
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) <u>Broncho pneumonia</u>								<u>2 days</u>		
DUE TO (b) <u>upper respiratory infection</u>								<u>7 days</u>		
DUE TO (c) _____										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>History of stroke, 1960</u> <u>Chronic Brain Syndrome & senile brain disease</u>								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. Deceased died from <u>Nov. 12, 1960</u> , to <u>Nov. 13, 1960</u> and last saw her ^{her} alive on <u>Nov. 12, 1960</u> <u>11/12/60</u> occurred at <u>6:30</u> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.										
22a. SIGNATURE (Degree or title) <u>Mary B Ames, M.D.</u>				22b. ADDRESS <u>St. Joseph, Missouri</u>				22c. DATE SIGNED <u>11/15/60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>11-1-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Graveland Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Weston, MO</u>					
24. FUNERAL DIRECTOR <u>Wynghen Funeral Home, Weston, MO</u>			ADDRESS _____		25. DATE RECD. BY LOCAL REG. <u>Nov. 15, 1960</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. Clark Goodell</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

M.B. Ames, M.D.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Dale L. Mart

Licensed Embalmer No. 510

P. O. Address ~~West~~

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.