

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-041112

FILED VS DEC 5 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 Gentry				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in lb 1 day		c. CITY OR TOWN Albany		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Hotel Robidoux			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location)			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SOLOMON Middle JACKINSON Last JACKINSON				4. DATE OF DEATH Month November Day 20 Year 1960				
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 6/5/1906	9. AGE (last birthday) 54	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) Administrator			10b. KIND OF BUSINESS OR INDUSTRY Gentry County Hosp.		11. BIRTHPLACE (City and state or country) New York, New York		12. CITIZEN OF WHAT COUNTRY U S A	
13a. FATHER'S NAME Unknown			13b. MOTHER'S MAIDEN NAME Unknown			14. NAME OF HUSBAND OR WIFE Unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W.W.#2			16. SOCIAL SECURITY NO. 082-05-4476		17. INFORMANT Coroner Records			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) Respiratory failure							INTERVAL BETWEEN ONSET AND DEATH At once	
DUE TO (b) Hypo 8 CC of Demerol Sol							About $\frac{1}{2}$ Hr.	
DUE TO (c) _____								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 2 Suicide notes							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 checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) Self administered Demerol						
20c. TIME OF INJURY Hour 10 Month, Day, Year 11-19-60		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Hotel Robidoux, St. Joseph Buchanan Missouri						
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.)		20f. CITY, TOWN, OR LOCATION COUNTY Buchanan STATE Missouri				
21. I, E. Meluney , viewed body Viewed body , to _____ and last saw him 11/20/60 Death occurred at 10:00P m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) E. Meluney M.D. Coroner				22b. ADDRESS 214 Kirkpatrick Bldg. St. Joseph, Mo.		22c. DATE SIGNED 11/20/60		
23a. BURIAL, CREMATION, REMOVAL (Specify) 11/22/Removal	23b. DATE 11/22/60	23c. NAME OF CEMETERY OR CREMATORY High Crown		23d. LOCATION (City, town, or county) (State) Excelsior Springs Missouri				
24. FUNERAL DIRECTOR Beards & Cochell Funeral Home			ADDRESS Albany, Mo.		25. DATE RECD. BY LOCAL REG. Nov. 23 1960	26. REGISTRAR'S SIGNATURE Wm. Clark Goodell		

DOCUMENT

E. Meluney, M.D. MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DEC 5 1960

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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 Charles E. Bennett

Licensed Embalmer No. 4677

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.