

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 5 1960

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Registrar's No. 1241

-60-041123

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 Mo b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph	Length of stay in lb 50yrs	c. CITY OR TOWN St. Joseph	Inside Limits Yes <input 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) 2522 So 11th
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) Sarah Fay McFadden	First Middle Last	4. DATE OF DEATH Nov. 26, 1960	Month Day Year
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5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Jan. 17, 1906	9. AGE (last birthday) 54	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Mound City Mo	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Phillip Sly	13b. MOTHER'S MAIDEN NAME Ora Sheppard	14. NAME OF HUSBAND OR WIFE none
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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. none	17. INFORMANT Mildred Wood, St. Joseph, Mo	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Empyema of left lung		INTERVAL BETWEEN ONSET AND DEATH unknown
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Lung Abscess	unknown
	DUE TO (c) Bronchiectasis	unknown
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	Month, Day, Year
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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 St. Joseph, Missouri	COUNTY Mo	STATE Mo
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21. I attended the deceased from **10/17/60** to **11/26/60** and last saw ^{her} ~~him~~ alive on **11/26/60**
Death occurred at **10:45 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Shera Elwaggoner M.D.</i>	(Degree or title) M.D.	22b. ADDRESS 301 Illinois Ave St. Joseph, Missouri	22c. DATE SIGNED 11/29/60
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23. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 11/28/60	23c. NAME OF CEMETERY OR CREMATORY Memorial Park, Cemetery St. Joseph, Mo	23d. LOCATION (City, town, or county) St. Joseph, Mo
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24. FUNERAL DIRECTOR <i>John P. Papp</i>	ADDRESS St. Joseph, Mo	25. DATE RECD. BY LOCAL REG. Dec. 1, 1960	26. REGISTRAR'S SIGNATURE <i>Mrs. Clark Goodell</i>
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DOCUMENT

BY AFFIDAVIT OF S.E. Waggoner, M.D. MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

~~city~~ _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

John T. Rupp

Licensed Embalmer No. *398*

P. O. Address *H. Payne*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.