

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-045195

FILED VS. DEC 27 1960 042

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STATE FILE NUMBER

INDEXED

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 yrs.		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 1720 Belle St.,			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1720 Belle St.,		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Jess Middle J. Last Henson				4. DATE OF DEATH Month December Day 15, 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 Sept. 10, 1883		9. AGE (last birthday) 77 IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HR: Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman			10b. KIND OF BUSINESS OR INDUSTRY Seitz Packing Co.		11. BIRTHPLACE (City and state or country) Iatan, Missouri		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME Edwin Henson			13b. MOTHER'S MAIDEN NAME Belle (unknown)			14. NAME OF HUSBAND OR WIFE Nannie Henson			
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. 491-10-2618		17. INFORMANT Address Nannie Henson, St. Joseph, Missouri				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Artery Disease - infarction							INTERVAL BETWEEN ONSET AND DEATH Sudden		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Old Coronary Artery Disease - Insufficiency							Yrs.		
DUE TO (c) Arteriosclerosis Gen							Yrs.		
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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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 10-24-56 to 12-15-60 and last saw him ^{her} alive on 11-26-60 Death occurred at 4:00 P. on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE Robert W. Kieber, M.D. (Degree or title)				22b. ADDRESS St. Joseph, Mo			22c. DATE SIGNED 12-17-60		
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE Dec. 17, 1960		23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery		23d. LOCATION (City, town, or county) (State) St. Joseph, Missouri			
24. FUNERAL DIRECTOR ADDRESS Meierhoffer-Fleeman Inc., St. Joseph, Mo.				25. DATE RECD. BY LOCAL REG. Dec. 21, 1960		26. REGISTRAR'S SIGNATURE Wm Clark Handell			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

R. W. Kieber, 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 by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Eric J. Adams*

Licensed Embalmer No. 4675

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.