

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-045220

FILED VS JAN 3 1961

042

Primary Registration District No. 1000

Registrar's No. 1333

STATE FILE NUMBER

NDED

1. PLACE OF DEATH a. COUNTY <u>Buchanan.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Lafayette</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>	Length of stay in lb	c. CITY OR TOWN <u>Higginsville</u>	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph State Hosp.</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>none</u>	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>WALTER</u> Middle <u>NEWMAN</u> Last <u>NEWMAN</u>			4. DATE OF DEATH Month <u>Dec.</u> Day <u>21</u> Year <u>1960</u>				
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 26 - 1879</u>	9. AGE (last birthday) <u>80</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>labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (City and state or country) <u>Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13a. FATHER'S NAME <u>CHARLES NEWMAN</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>none</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>State Hosp. Record.</u>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anemia and malnutrition</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Castro - Gutted Hemorrhage</u>		<u>Unknown</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)			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 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 Dec 21 - 1960 to Dec 21 - 1960 and last saw him alive on Dec 21 - 1960
Death occurred at Dec 21 1960 6:15 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>William Paul Taha M.D.</u>		22b. ADDRESS <u>St. Joseph State Hosp.</u>		22c. DATE SIGNED <u>12-21-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>	23b. DATE <u>12/22/1960</u>	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) <u>Higginsville Mo.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Wheaton - Bowman, St Joseph Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Dec. 28, 1960</u>		26. REGISTRAR'S SIGNATURE <u>Mr. Clark Goodell</u>	

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

M. Tahir, 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 Eugene Wood

Licensed Embalmer No. 3804

P. O. Address 319 20th St

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.