

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-045250

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STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>		Length of stay in 1b <b>49 years</b>		c. CITY OR TOWN <b>St. Joseph</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>2315 Lafayette St.</b>			d. STREET ADDRESS (If outside, give location) <b>2315 Lafayette St.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>EMMA</b> Middle <b>LOUISE</b> Last <b>WYANT</b>			4. DATE OF DEATH Month <b>December</b> Day <b>11</b> Year <b>1960</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>4/21/1872</b>	9. AGE (last birthday) <b>88</b> 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) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (City and state or country) <b>Oconomowoc, Wisc.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Carl Ebel</b>		13b. MOTHER'S MAIDEN NAME <b>Henrietta unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Frederick</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT Address <b>Mrs. Arthur Brunke, 2315 Lafayette, St. Joseph</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Heart Disease &amp; Failure</b> DUE TO (b) <b>Hypertension Arterial</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <b>6 months+</b> <b>6 months+</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b> Pernicious Anemia</b>				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. I attended the deceased from <b>11-16-60</b> to <b>12-11-60</b> and last saw her alive on <b>12-11-60</b> Death occurred at <b>11:35 a.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <b>H. C. Senne, M.D.</b> (Degree or title)			22b. ADDRESS <b>223 N. 7th St. Joseph, Mo.</b>		22c. DATE SIGNED <b>12-13-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>12/14/1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Joseph Mo.</b>		
24. FUNERAL DIRECTOR <b>Heatow Bowman</b> ADDRESS <b>St. Joseph, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>Dec. 15, 1960</b>		26. REGISTRAR'S SIGNATURE <b>Wm. Clark Goodell</b>		

DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

**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 William Spalding

Licensed Embalmer No. 4535

P. O. Address St. Joseph

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.