

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-000289

FILED VS FEB 14 1961

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 149

STATE FILE NUMBER

DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 H.C. Senne, M.D.
 BY AFFIDAVIT OF
 SHOULD READ
 ITEM 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 1b 1 week	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 825 Vine St.,			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 101 South Dallas St.,	
3. NAME OF DECEASED (Type or print) First Middle Last Candie May Cox			4. DATE OF DEATH Month Day Year February 7, 1961		
5. SEX Female	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 May 31, 1894	9. AGE (last birthday) 66
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (City and state or country) Harrison Co., Missouri		12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Thomas M. Rice		13b. MOTHER'S MAIDEN NAME Evalina Fanning		14. NAME OF HUSBAND OR WIFE Logan Cox	
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 Address M.R. Carmack, Kansas City, 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) <i>Rheumatic Heart Disease & Failure 6 yrs.</i>					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b)			
		DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Auricular Fibrillation</i>				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 Month, Day, Year a.m. p.m.					
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 <i>12-16-60</i> to <i>2-7-61</i> and last saw her <i>him</i> alive on <i>2-4-61</i> Death occurred at <i>9:20</i> <i>P.m.</i> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>H.C. Senne M.D.</i>			22b. ADDRESS <i>223 N 7th St. Joseph Mo</i>		22c. DATE SIGNED <i>2-9-61</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>	23b. DATE <i>Feb. 7, 1961</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Grand View Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>Albany, Missouri</i>		
24. FUNERAL DIRECTOR ADDRESS <i>Meierhoffer-Fleeman Inc., St. Joseph, Mo.</i>		25. DATE RECD. BY LOCAL REG. <i>Feb. 10, 1961</i>	26. REGISTRAR'S SIGNATURE <i>Wm. Clark Handell</i>		

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Eric J. Cherry*

Licensed Embalmer No. 4679

P. O. Address St Joseph, Mo.

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.