

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-004679  
STATE FILE NUMBER

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 179

AMENDED

FILED VS FEB 27 1961

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>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>		Length of stay in 1b <b>2yr. 2mo. 21days</b>	c. CITY OR TOWN <b>Kansas City</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>State Hospital #2</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b></b>
Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>HELEN</b> Middle <b>MAY</b> Last <b>WIRENE</b>			4. DATE OF DEATH Month <b>February</b> Day <b>11</b> Year <b>1961</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 type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>5/15/1901</b>	9. AGE (last birthday) <b>59</b>	IF UNDER 1 YEAR Months <b></b> Days <b></b>
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>Indiana</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>G. W. May</b>		13b. MOTHER'S MAIDEN NAME <b>Jeanetta Riddle</b>		14. NAME OF HUSBAND OR WIFE <b></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>unknown</b>	17. INFORMANT Address <b>Mrs. John Hillis, 3000 E. 49th, Kansas City, Mo</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Broncho Pneumonia</b>		<b>2 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>General debility</b>	<b>2 days</b>
	DUE TO (c) <b>Involutional melancholia</b>	<b>31 years</b>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)  
**Woman has been a patient in St. Joseph's State Hosp. since Nov. 20, 1939** Yes  No  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.) <b>Involutional melancholia</b>
20c. TIME OF INJURY Hour <b></b> a.m. <b></b> p.m. <b></b> Month, Day, Year <b></b>	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.) <b></b>	20f. CITY, TOWN, OR LOCATION <b></b>	COUNTY <b></b> STATE <b></b>

21. I attended the deceased from **Feb. 10, 1961** to **Feb. 11, 1961** and last saw her/him alive on **Feb. 11, 1961**  
Death occurred at **9:20 p.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>H. F. Mundy M.D.</b> (Degree or title)	22b. ADDRESS <b>State Hospital, St. Joseph, Mo.</b>	22c. DATE SIGNED <b>2-12-61</b>
---	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	23b. DATE <b>2/12/1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b></b>	23d. LOCATION (City, town, or county) (State) <b>Knoxville, Iowa</b>
---	-------------------------------	---	---

24. FUNERAL DIRECTOR <b>Heston Beaman</b> ADDRESS <b>St. Joseph, Mo</b>	25. DATE RECD. BY LOCAL REG. <b>Feb. 17, 1961</b>	26. REGISTRAR'S SIGNATURE <b>Mrs. Clark Goodell</b>
---	--	--

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

H.F. Mundy, M.D. 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 me,  
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 314 South St. HJ

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.