

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-012628

AMENDED FILED MAY 15 1961 Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 467 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clinton</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>			Length of stay in Ib <u>5 days</u>		c. CITY OR TOWN <u>Plattsburg</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mo. Methodist Hosp.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Jim</u> Middle <u>Lawrence</u> Last <u>Aitken</u>				4. DATE OF DEATH Month <u>May</u> Day <u>6</u> Year <u>1961</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</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>10-8/1880</u>	9. AGE (last birthday) <u>80</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Decorating</u>		11. BIRTHPLACE (City and state or country) <u>Stephensville Texas U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>William Aitken</u>			13b. MOTHER'S MAIDEN NAME <u>Alice Sheets</u>		14. NAME OF HUSBAND OR WIFE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				17. INFORMANT <u>Paul Aitken 530 1st Street Napa, Calif.</u>			
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) <u>CEREBRO-VASCULAR THROMBOSIS</u>						<u>7 DAYS</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						DUE TO (b) <u>ARTERIOSCLEROSIS</u>	
DUE TO (c)						<u>YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>NEPHRITIS CHRONIC</u>					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 <u>APRIL 29, 1961</u> to <u>MAY 6, 1961</u> and last saw <u>him</u> alive on <u>MAY 6, 1961</u> Death occurred at <u>3:30</u> <u>P</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Gillen Spelman M.D.</u>				22b. ADDRESS <u>706 FRANCIS, St. Joseph, Mo</u>		22c. DATE SIGNED <u>5-7-61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>5/8/1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn</u>		23d. LOCATION (City, town, or county) (State) <u>Plattsburg, Missouri</u>		
24. FUNERAL DIRECTOR <u>Eyon Funeral Home, Plattsburg, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>May 7, 1961</u>		26. REGISTRAR'S SIGNATURE <u>Wm Clark Goodell</u>		

DATE AMENDED

INS. READ OF

DOCUMENT

BY AFFIDAVIT OF Al Herman, M.D. MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

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 Phillip E. Cook

Licensed Embalmer No. 4493

P. O. Address Hamburg, Pa

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.