

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-016538

STATE FILE NUMBER

AMENDED

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 561

**FILED JUN 12 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>Buchanan</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Rural: Washington Twp.</b>	Length of stay in 1b <b>60 years</b>	c. CITY OR TOWN <b>St. Joseph</b>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>2 1/2 miles S.E. of St. Joseph</b>		d. STREET ADDRESS (If outside, give location) <b>R. R. #4</b>	Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>HARVEY</b> Middle <b>FRANCIS</b> Last <b>FRANCIS</b>	4. DATE OF DEATH Month <b>May</b> Day <b>29</b> Year <b>1961</b>
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5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>12/9/1885</b>	9. AGE (last birthday) <b>75</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HR Hours <b>0</b> Min. <b>0</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>farmer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>farm</b>	11. BIRTHPLACE (City and state or country) <b>Iowa</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>Thomas Francis</b>	13b. MOTHER'S MAIDEN NAME <b>Jane Allen</b>	14. NAME OF HUSBAND OR WIFE <b>Mary</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	17. INFORMANT Address <b>Mrs. Mary Francis R. R. #4, St. Joseph, Mo.</b>
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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 <b>24 hrs</b>
IMMEDIATE CAUSE (a) <b>Heart Attack</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Auto intoxication</b>	
	DUE TO (c) <b>Kidney involvement</b>	<b>Several years</b>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Paralysis agitans</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
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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.)
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20c. TIME OF INJURY Hour <b>6:00</b> a.m. p.m.	Month, Day, Year <b>1956</b>
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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 <b>St. Joseph</b>	COUNTY <b>Mo.</b>	STATE
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21. I attended the deceased from **1956** to **1961** and last saw her alive on \_\_\_\_\_  
Death occurred at **6:00 a.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>G. F. Kimball MD</b> (Degree or title)	22b. ADDRESS <b>3816 Seneca, St. Joseph, Mo.</b>	22c. DATE SIGNED <b>6/1/61</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>5/31/1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Joseph Mo.</b>
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24. FUNERAL DIRECTOR <b>Neaton Bowman</b> ADDRESS <b>St. Joseph, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>June 6, 1961</b>	26. REGISTRAR'S SIGNATURE <b>Mrs. Clark Gardell</b>
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DATE AMENDED  
 INSTEAD OF  
 DOCUMENT  
 SHOULD READ  
 BY AFFIDAVIT OF  
 MEDICAL CERTIFICATION  
 G. F. Kimball, 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 me,  
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 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.