

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-016619

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

042

1000

576

STATE FILE NUMBER

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

FILED JUN 12 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

M.H. Christ, M.D. MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Buchanan				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph			Length of stay in lb Life		c. CITY OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Hillside Rest Home				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 20th and Mitchell Ave.	
3. NAME OF DECEASED (Type or print) First Jennie Middle K. Last Wyatt				4. DATE OF DEATH Month June Day 2 Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH March 7, 1873	
						9. AGE (last birthday) 88	
						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) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (City and state or country) St. Joseph, Missouri	
12. CITIZEN OF WHAT COUNTRY U.S.A.							
13a. FATHER'S NAME Daniel Sims				13b. MOTHER'S MAIDEN NAME Sarah Kay		14. NAME OF HUSBAND OR WIFE Charles Wyatt	
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 Mrs. Jack Maupin Address Long Beach, Calif.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO (b) with Congestive Failure DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Generalized Arteriosclerosis with Senescence.						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 SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 Jan 1960 to June 27, 1961 and last saw her alive on Mar 27, 1961 Death occurred at 4:35 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) M.H. Christ, M.D.				22b. ADDRESS 6106 King Hill Ave		22c. DATE SIGNED 6/6/61	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE June 5, 1961		23c. NAME OF CEMETERY OR CREMATORY Ashland Cemetery		23d. LOCATION (City, town, or county) (State) St. Joseph, Missouri	
24. FUNERAL DIRECTOR Meierhoffer-Fleeman Inc. ADDRESS St. Joseph, Mo.				25. DATE RECD. BY LOCAL REG. June 7, 1961		26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell	

JUN 22 1961

1961 JUN 8 PMS

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 Raymond H. Hoover

Licensed Embalmer No. 5147

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.