

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-020446

STATE FILE NUMBER

AMENDED

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 612

FILED JUN 19 1961

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in 1b 31 yrs.	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 Mo. Methodist Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1709 Howard Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First WALTER Middle J. Last ENGLE	4. DATE OF DEATH Month June Day 13 Year 1961
---	--

5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 30, 1882	9. AGE (last birthday) 78	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) Re. Carpenter	10b. KIND OF BUSINESS OR INDUSTRY Bldg.	11. BIRTHPLACE (City and state or country) Big Rapids Michigan	12. CITIZEN OF WHAT COUNTRY U.S.A.
---	---	--	--

13a. FATHER'S NAME John Engle	13b. MOTHER'S MAIDEN NAME SARA Sara?	14. NAME OF HUSBAND OR WIFE US?A?
---	--	---

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 Walter Engle, Jr. St. Joseph, Mo.
---	--	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute posterior coronary occlusion		INTERVAL BETWEEN ONSET AND DEATH 2 wks
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)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 _____ s.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 3/17/1950 to 6/13/61 and last saw him alive on 6/12/61
Death occurred at 12:40 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Quincy Lewis MD</i> (Degree or title)	22b. ADDRESS Social Welfare Board 10th & Olive, St. Joseph, Mo.	22c. DATE SIGNED 6/14/61
---	--	---------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 6/16/61	23c. NAME OF CEMETERY OR CREMATORY Courter Cemetery	23d. LOCATION (City, town, or county) (State) Troy Kasas
--	-----------------------------	---	--

24. FUNERAL DIRECTOR <i>John E. Sepp</i>	ADDRESS St. Joseph, Mo	25. DATE RECD. BY LOCAL REG. June 16, 1961	26. REGISTRAR'S SIGNATURE <i>Mrs. Clark Handell</i>
---	----------------------------------	--	--

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

O.W.D. Craig, M.D.

