

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-024130

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

042

1000

793

STATE FILE NUMBER

AMENDED

Registration District No. Primary Registration District No. Registrar's No.

FILED AUG 14 1961

1. PLACE OF DEATH a. COUNTY Buchanan				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Andrew					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in lb 2 weeks		c. CITY OR TOWN Helena		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Missouri Methodist Hosp.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First MILLARD Middle HEATH Last HEATH			4. DATE OF DEATH Month August Day 2 Year 1961						
5. SEX male	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 4/8/1900	9. AGE (last birthday) 61	IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HR Hours 0 Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer			10b. KIND OF BUSINESS OR INDUSTRY farm		11. BIRTHPLACE (City and state or country) Union Star, Mo.		12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME George Heath			13b. MOTHER'S MAIDEN NAME Minnie Kelly			14. NAME OF HUSBAND OR WIFE Bertha			
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.		17. INFORMANT Mrs. Bertha Heath, Helena, Mo.			Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphosarcoma							INTERVAL BETWEEN ONSET AND DEATH 2 yrs		
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 type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input checked="" 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 Jan '40 to death and last saw her/him alive on 8-2-61 Death occurred at 10:30 p. m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE Joseph L. Fisher M.D. (Deed to or title)				22b. ADDRESS 702 Julie St.				22c. DATE SIGNED 8-5-61	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 8/5/1961	23c. NAME OF CEMETERY OR CREMATORY Ashland Cemetery		23d. LOCATION (City, town, or county) St. Joseph Mo.		(State)		
24. FUNERAL DIRECTOR Nestor Bowman ADDRESS St. Joseph, Mo.			25. DATE RECD. BY LOCAL REG. Aug 7, 1961		26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell				

DATE AMENDED

INSTEAD OF THIS RECORD ARE AS FOLLOWS

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

J.L. Fisher, M.D., MEDICAL CERTIFICATION

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.