

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-024205

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

042

1000

772

STATE FILE NUMBER

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

AMENDED

FILED AUG 7 1961

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|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Buchanan | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri. COUNTY Chariton | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph | | Length of stay in 1b 51 yrs | c. CITY OR TOWN Shannondale |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph State Hospital | | Inside Limits <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|--|---------------------------|---|--|--|--------------------------------|---------------------------------------|
| 3. NAME OF DECEASED (Type or print) First Middle Last Carrie White | | | 4. DATE OF DEATH Month Day Year July 30 1961 | | | |
| 5. SEX Female | 6. COLOR OR RACE Negro | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 1882 | 9. AGE (last birthday) about 79 | 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 at home | | 11. BIRTHPLACE (City and state or country) Missouri | | 12. CITIZEN OF WHAT COUNTRY U.S.A. |
| 13a. FATHER'S NAME Unknown | | 13b. MOTHER'S MAIDEN NAME Unknown | | 14. NAME OF HUSBAND OR WIFE M.S. White | | |

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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) No | 16. SOCIAL SECURITY NO. None | 17. INFORMANT Address Records, State Hospital #2, St. Joseph |
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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: IMMEDIATE CAUSE (a) Hypostatic pneumonia | | INTERVAL BETWEEN ONSET AND DEATH 2 days |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) Stroke | 10 days |
| | DUE TO (c) Arteriosclerosis | 10 yrs. |
| 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 |

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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.) |
| 20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year | | |

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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 COUNTY STATE |
| 21. I attended the deceased from 7-30-1961 to 7-30-1961 and last saw her live on 7-30-1961 Death occurred at 2:28 p m on the date stated above, and to the best of my knowledge, from the causes stated. | | |

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| 22a. SIGNATURE (Degree or title) C.F. Cossins M.D. C.F. Cossins M.D. | 22b. ADDRESS St. Joseph State Hospital | 22c. DATE SIGNED 7-30-61 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE July 31, '61 | 23c. NAME OF CEMETERY OR CREMATORY Kirkville, Missouri |

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| 24. FUNERAL DIRECTOR ADDRESS Wm. H. Alexander, St. Joseph, Mo. | 25. DATE RECD. BY LOCAL REG. July 30, 1961 | 26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell |
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

C.F. Cossins 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 Wm. H. Alexander

Licensed Embalmer No. 4450

P. O. Address St Joseph

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.