

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-035968

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 1030

STATE FILE NUMBER

FILED OCT 23 1961

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>		Length of stay in lb <u>30 yrs</u>		c. CITY OR TOWN <u>St. Joseph</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Josephs Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>1515 So. 10th St.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>LEFA</u> Middle <u>HAZEL</u> Last <u>HORNBUCKLE</u>				4. DATE OF DEATH Month <u>October</u> Day <u>4</u> Year <u>1961</u>									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>3/23/1894</u>		9. AGE (last birthday) <u>67</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HR Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (City and state or country) <u>Daviess County Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U S A</u>					
13a. FATHER'S NAME <u>Albert Nickson</u>				13b. MOTHER'S MAIDEN NAME <u>Nettie Hook</u>				14. NAME OF HUSBAND OR WIFE <u>Elmer L. (Deceased)</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Mr. Jerry Hornbuckle</u>		Address <u>1515 So. 10th St. Joseph, Mo.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u>										INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last: DUE TO (b) <u> </u> DUE TO (c) <u> </u>										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			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u> </u>				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 <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.) <u> </u>									
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u>		Month, Day, Year <u> </u>		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.) <u> </u>		20f. CITY, TOWN, OR LOCATION <u> </u>		COUNTY <u> </u>		STATE <u> </u>							
21. I attended the deceased from <u>April 1958</u> to <u>10-4-61</u> and last saw <u>her</u> live on <u>10-4-61</u>				Death occurred at <u>11:45P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree title) <u>J.L. Mothershead M.D.</u>				22b. ADDRESS <u>2603 Fredrick</u>				22c. DATE SIGNED <u>10-13-61</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>10/7/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>				23d. LOCATION (City, town, or county) (State) <u>St. Joseph Missouri</u>					
24. FUNERAL DIRECTOR <u>Stamper Funeral Home N.S.</u>				ADDRESS <u>St. Joseph, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Oct. 16, 1961</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. Clark Stoddell</u>					

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF
J.L. Mothershead M.D. VERIFICATION

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 Charles E. Bennett

Licensed Embalmer No. H677

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.