

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-040150

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

042

Primary Registration District No. 1000

Registrar's No. 1163

STATE FILE NUMBER

AMENDED

FILED NOV 24 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 45yrs		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 St. Joseph Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 703 Riverview Drive		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mildred Middle Opal Last Berry				4. DATE OF DEATH Month Nov Day 14 , 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 Sept 15, 1898	9. AGE (last birthday) 63	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (City and state or country) Missouri City, Mo		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME James Stafford			13b. MOTHER'S MAIDEN NAME Lura Mullins Mullins			14. NAME OF HUSBAND OR WIFE none		
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 Dorothy Young, 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) CVA & hemiplegia DUE TO (b) Hypertensive Arteriosclerotic DUE TO (c) Cardio Vascular disease						INTERVAL BETWEEN ONSET AND DEATH approx 4dg ?		
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 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 <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. Month, Day, Year								
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 3-30-61 to 11/14/61 and last saw her ^{her} alive on 11-14-61 Death occurred at 9:30 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <i>[Signature]</i> (Degree or title)				22b. ADDRESS 316 No. 10th St Joseph Mo.		22c. DATE SIGNED 11-15-61		
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried	23b. DATE 11/17/61	23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery		23d. LOCATION (City, town, or county) St. Joseph, Mo		23e. (State)		
24. FUNERAL DIRECTOR <i>[Signature]</i> ADDRESS St. Joseph, Mo			25. DATE RECD. BY LOCAL REG. Nov. 20, 1961		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

DATE AMENDED

INSTEAD OF

DOCUMENT

SHOULD READ

BY AFFIDAVIT OF

MEDICAL CERTIFICATION
[Signature]

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 _____

John E. Repp

Licensed Embalmer No. 3986

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.