

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-040214

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 1177

STATE FILE NUMBER

AMENDED **FILED NOV 24 1961**

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>Buchanan</u>		a. STATE <u>Missouri</u> b. COUNTY <u>Clinton</u>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>		Length of stay in 1b <u>3 Months</u>	c. CITY OR TOWN <u>Plattsburg</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hosp. No. 2</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) <u>Warren Baumier Rest Home</u> Residence on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Hubert</u> Middle <u>Maddox</u> Last <u>Maddox</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>17,</u> Year <u>1961</u>
5. SEX <u>Male</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>4/21/1875</u>
		9. AGE (last birthday) <u>86</u>	IF UNDER 1 YEAR Months <u> </u> Days <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>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (City and state or country) <u>Gower, Missouri</u>
10c. CITIZEN OF WHAT COUNTRY		12. CITIZEN OF WHAT COUNTRY	
13a. FATHER'S NAME <u>Not Known</u>		13b. MOTHER'S MAIDEN NAME <u>Not Known</u>	
14. NAME OF HUSBAND OR WIFE <u>Lucy Maddox</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Cecil Norris, St. Joseph,</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>
IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u>			
DUE TO (b) <u>General Arteriosclerosis</u>			
DUE TO (c) <u> </u>			
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 * SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 <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.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from <u>11/16/61</u> to <u>11/17/61</u> and last saw ^{her} him alive on <u>11/16/61</u>		Death occurred at <u>4:00 A.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>Forrest Thomas M.D.</u>		22b. ADDRESS <u>St. Joe Mo. Sp. Clinic Hosp No 2</u>	22c. DATE SIGNED <u>11/17-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>11/17/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hebron Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Buchanan County, Mo.</u>
24. FUNERAL DIRECTOR <u>Lyon Funeral Home, Plattsburg, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Nov. 19, 1961</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Clark Hardell</u>

DATE AMENDED

INSTEAD OF

DOCUMENT

SHOULD READ

BY AFFIDAVIT OF

F. Thomas, 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 Darrell D. Lyon

Licensed Embalmer No. 3640

P. O. Address Plattsburg, 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.