

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**=61-043663**  
STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE **042**

1000

1352

Registration District No.

Primary Registration District No.

Registrar's No.

AMENDED

**FILED JAN 8 1962**

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Kansas</b> b. COUNTY <b>Doniphan</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>		c. CITY OR TOWN <b>Highland</b>	
Length of stay in 1b <b>6 days</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Josephs Hospital</b>		d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <b>NELLIE HARGIS</b>			4. DATE OF DEATH Month Day Year <b>December 29, 1961</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>9/17/1870</b>	9. AGE (last birthday) <b>91</b>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (City and state or country) <b>Marysville, Kansas</b>	
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13a. FATHER'S NAME <b>James Magill</b>		13b. MOTHER'S MAIDEN NAME <b>Ella Christian</b>	
14. NAME OF HUSBAND OR WIFE <b>W. H. Hargis</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>W. J. Hargis, Highland, Kansas</b>		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	

IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b>		1 week	
DUE TO (b) <b>Arteriosclerotic Heart Disease</b>		years	
DUE TO (c)			

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Arteriosclerotic Nephritis</b>		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			

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 <b>Highland</b>	COUNTY <b>Kansas</b>	STATE
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21. I attended the deceased from **12-23-61** to **12-29-61** and last saw **her** alive on **12-29-61**  
Death occurred at **9:40 a.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Allen J. Herman M.D.</i>	(Degree or title)	22b. ADDRESS <b>706 Francis St. Joseph, Mo.</b>	22c. DATE SIGNED <b>1-3-62</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	23b. DATE <b>12/29/1961</b>	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) <b>Highland Kansas</b>
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24. FUNERAL DIRECTOR <i>Heston Bouman</i>	ADDRESS <b>St. Joseph, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>Jan. 4, 1962</b>	26. REGISTRAR'S SIGNATURE <i>Wm. Clark Kendall</i>
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED  
INSTEAD OF  
DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF  
ITEM NO. SHOULD READ

*Allen J. Herman, 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 William Spallone

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.