

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-043690

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 1328 STATE FILE NUMBER

FILED JAN 2 1962

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Andrew</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>	Length of stay in lb <u>20 years</u>	c. CITY OR TOWN <u>Nodaway</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 Hospital No. 2</u>		d. STREET ADDRESS (If outside, give location)	Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Goldie</u> Middle <u>Marie</u> Last <u>Millhollen</u>			4. DATE OF DEATH Month <u>December</u> Day <u>27</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 type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>9/30/1911</u>	9. AGE (last birthday) <u>50</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>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (City and state or country) <u>Nodaway Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U S A</u>
13a. FATHER'S NAME <u>Cornelius Calvert</u>			13b. MOTHER'S MAIDEN NAME <u>Rosie Clark</u>		14. NAME OF HUSBAND OR WIFE <u>None</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 Address <u>Mrs. Bessie Duncan Nodaway, Mo.</u>		

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) <u>Pulmonary Tuberculosis</u>		<u>4 yrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	
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 <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 6/19/33 to 12/27/61 and last saw her live on 12/26/61
Death occurred at 2:00A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>C. Smith M.D.</u>		22b. ADDRESS <u>State Hospital No. 2</u>		22c. DATE SIGNED <u>12/27/61</u>
23a. BURIAL / CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12/30/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Johns Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Amazonia, Missouri</u>	

24. FUNERAL DIRECTOR <u>Stamey Funeral Home</u> ADDRESS <u>St. Joseph, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Dec. 29, 1961</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Clark</u>
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

DOCUMENT

BY AFFIDAVIT OF C. Smith, M.D. MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

JAN 3 1962

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. 4677

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.