

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-046973

FILED DEC 18 1961

Registration District No. **318** Primary Registration District No. **1003**

Registrar's No. **11452**

STATE FILE NUMBER

AMENDED

DATE AMENDED

INSTEAD OF

DOCUMENT

1. PLACE OF DEATH a. COUNTY b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis Length of stay in lb c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Incarante Word Hosp. Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY ST. CHARLES c. CITY OR TOWN St. Charles Missouri Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS R.R. (1) (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>				
3. NAME OF DECEASED First John Middle Wright Last Washington			4. DATE OF DEATH Month Dec. Day 7, Year 1961			
5. SEX male	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3-27-1872	9. AGE (last birthday) 89	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired farmer and		10b. KIND OF BUSINESS OR INDUSTRY caretaker		11. BIRTHPLACE (City and state or country) Penn.		12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Edward Washington			13b. MOTHER'S MAIDEN NAME unknown		14. NAME OF HUSBAND OR WIFE Anna Washington	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no none				17. INFORMANT Address Mrs. Lena Collins R.R.(1) St. Charles 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) <i>Generalized Carcinomatous</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Primary Carcinoma of Prostate</i> DUE TO (c) <i>177x</i> 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 _____ 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		COUNTY STATE		
21. I attended the deceased from <i>11-20-61</i> to <i>12-7-61</i> and last saw him <i>live on</i> <i>12-7-61</i> Death occurred at <i>9:30 P</i> m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Ink or title) <i>Herman J. Kloche M.D.</i>			22b. ADDRESS <i>9616 Pauldand Rd.</i>		22c. DATE SIGNED <i>12-8-61</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE Dec. 8, 1961	23c. NAME OF CEMETERY OR CREMATORY Manhattan Kansas Local		23d. LOCATION (City, town, or county) (State) Manhattan, Kansas	
24. FUNERAL DIRECTOR ADDRESS C.R. Lupton and Sons 7233 Delmar Bly'd.			25. DATE RECD. BY LOCAL REG. DEC 8 1961	26. REGISTRAR'S SIGNATURE <i>Neal Smith M.D.</i>		

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

HA. 7-1855

1:30 To 4:00 Friday

City Vice

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 Clarence A. Murray

Licensed Embalmer No. 4011

P. O. Address H. Lewis, M

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.