

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-009978

STATE FILE NUMBER

042

1000

399

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

DO NOT WRITE ON THIS STUB

AMENDED

FILED APR 16 1962

1. PLACE OF DEATH a. COUNTY Buchanan b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph, Missouri Length of stay in 1b 10 years c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Missouri Methodist Hospital Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan c. CITY OR TOWN St. Joseph, Missouri Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) 2345 Ashland Avenue Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
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3. NAME OF DECEASED (Type or print) First FRANCIS Middle E. Last McCLEERY			4. DATE OF DEATH Month March Day 17 Year 1962		
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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 Apr. 15, 1885	9. AGE (last birthday) 78	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Divisional Manager	10b. KIND OF BUSINESS OR INDUSTRY Canadian, Swift & Co.	11. BIRTHPLACE (City and state or country) New Castle, Pennsylvania	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME James McCleery	13b. MOTHER'S MAIDEN NAME Vogan	14. NAME OF HUSBAND OR WIFE Janet McCleery
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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. _____	17. INFORMANT Address Mrs. Janet McCleery - St. Joseph, Missouri
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18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brainial Anemia Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) cerebral thrombosis DUE TO (c) _____	INTERVAL BETWEEN ONSET AND DEATH 12 hrs 3 min.
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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
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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.)
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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"/>
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20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
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21. I attended the deceased from 12-12-61 to 3-17-62 and last saw her/him alive on 3-17-62.
 Death occurred at 11:02 PM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>J.H. Ryan M.D.</i> (Degree or title)	22b. ADDRESS <i>St. Joseph MO</i>	22c. DATE SIGNED <i>4.6.62</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) Entombment	23b. DATE March 21, 1962	23c. NAME OF CEMETERY OR CREMATORY Ashland Mausoleum	23d. LOCATION (City, town, or county) (State) St. Joseph, Missouri
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24. FUNERAL DIRECTOR ADDRESS Meierhoffer-Fleeman Inc., St. Joseph, Mo.	25. DATE RECD. BY LOCAL REG. April 13, 1962	26. REGISTRAR'S SIGNATURE <i>Mrs. Clark Goodell</i>
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DATE AMENDED
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF
SHOULD READ
ITEM NO.

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF *J.H. Ryan, M.D.*

USE BLACK INK OR TYPEWRITER RIBBON

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 Raymond H. Trose

Licensed Embalmer No. 5147

P. O. Address St Joseph Pa

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.