

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-014178

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

042

1000

453

STATE FILE NUMBER

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

DO NOT WRITE ON THIS STUB

AMENDED

FILED APR 30 1962

VS 300
Rev. 4/59

15117

2 1020

3

4 0

5 0

6

7 0

8 2

9 4200

10

11

12 93-0

13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

F. Thomas, M.D. MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Shelby	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in 1b 1 1/2 yr, 6 mo. 7 days	c. CITY OR TOWN Clarence Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hospital #2		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) State Hospital #2 Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Frank Middle Althof Last Althof			4. DATE OF DEATH Month April Day 23 Year 1962
5. SEX male	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH unknown
9. AGE (last birthday) 86		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Lentner, Mo.
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME Charles Althof	
13b. MOTHER'S MAIDEN NAME unknown		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. unknown	17. INFORMANT State Hospital #2 Records, St. Joseph, Mo. Address _____
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) coronary thrombosis			INTERVAL BETWEEN ONSET AND DEATH 2-12 hours
DUE TO (b) arteriosclerotic heart disease			years _____
DUE TO (c) _____			years _____
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 4/23/62 to 4/23/62 and last saw her/him alive on 4/23/62 Death occurred at 9:15 a. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) F. Thomas M.D.		22b. ADDRESS State Hospital #2, St. Joseph, Mo	22c. DATE SIGNED 4/27/62
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVED	23b. DATE 4/23/1962	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) Shelbina Missouri
24. FUNERAL DIRECTOR Heston Bauman ADDRESS St. Joseph, Mo.		25. DATE RECD. BY LOCAL REG. April 23, 1962	26. REGISTRAR'S SIGNATURE Mr. Clark Goodell

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 Ernest Wood

Licensed Embalmer No. 3804
P. O. Address 319 So 10th St, Memphis, 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.