

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-026129

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 861 STATE FILE NUMBER

FILED JUL 30 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

C.F. Cassin, M.D. MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in 1b 50yrs	c. CITY OR TOWN St. Joseph, Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hosp. #2		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 117 W Michel Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Laura Jane Lisle			4. DATE OF DEATH Month Day Year July 21, 1962
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH May 8, 1899
9. AGE (last birthday) 63		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY self	11. BIRTHPLACE (City and state or country) Stewratsville, Mo
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME James Barnett	
13b. MOTHER'S MAIDEN NAME Grace Lisle		14. NAME OF HUSBAND OR WIFE none	
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. unk	17. INFORMANT Address Fay Lisle, St. Joseph, 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) Cerebral embolism Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Bronco-Pneumonia DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 7-8-62 7-8-62
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 checked="" 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.	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 7/21/62 to 7/21/62 and last saw her him alive on 7/21/62. Death occurred at 7:25 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) C.F. Cassin M.D.		22b. ADDRESS State Hospital #2 St. Joseph, Mo	22c. DATE SIGNED 7/21/62
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 7/24/62	23c. NAME OF CEMETERY OR CREMATORY Stewartsville, Cemetery	23d. LOCATION (City, town, or county) (State) Stewartsville, Mo
24. FUNERAL DIRECTOR John [Signature]	ADDRESS St. Joseph, Mo	25. DATE RECD. BY LOCAL REG. July 26, 1962	26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell

USE BLACK INK OR TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

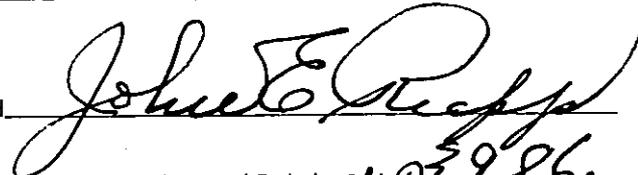
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

~~or by~~ _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____



Licensed Embalmer No. 3986

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.