

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-030093

STATE FILE NUMBER

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 947

FILED AUG 27 1962

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1 5117

2 0910

3 2

4 0

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7 0

8 2

9 4222

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11

12 93-0

13 1-0

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF F. Thomas M.D. MEDICAL CERTIFICATION

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>Buchanan</u>		a. STATE <u>MO</u> b. COUNTY <u>Davies</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>		c. CITY OR TOWN <u>Alatamont</u>	
Length of stay in 1b		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital #2</u>		d. STREET ADDRESS <u>XX</u> (If outside, give location)	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH
First <u>William</u> Middle <u>C</u> Last <u>Hughes</u>			Month <u>July</u> Day <u>29</u> Year <u>1962</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>not given</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) <u>76?</u>
11a. BIRTHPLACE (City and state or country) <u>Davies Co, Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>not given</u>		14. NAME OF HUSBAND OR WIFE <u>none</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Hospital records</u>		Address	
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>Chronic Myocardis</u>			
DUE TO (b) <u>Generalized Arteriosclerosis</u>			
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>5:20</u> a.m. <u>P.M.</u> Month, Day, Year <u>Aug 21, 1961</u>	20f. CITY, TOWN, OR LOCATION <u>St. Joseph, Mo</u> COUNTY <u>Mo</u> STATE <u>Mo</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.)	
21. I attended the deceased from <u>Aug 21, 1961</u> to <u>July 29, 1962</u> and last saw her alive on <u>July 29, 1962</u> Death occurred at <u>5:20 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Forrest Thomas M.D.</u> (Degree or title)		22b. ADDRESS <u>Dr. Hop No 2 St Joseph Mo</u>	
22c. DATE SIGNED <u>7/29/62</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>7/31/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>School of Osteopathy</u>		23d. LOCATION (City, town, or county) <u>Kirkville, Mo</u> (State)	
24. FUNERAL DIRECTOR <u>John E. Rupp</u> ADDRESS <u>St. Joseph, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>Aug 20, 1962</u>	
26. REGISTRAR'S SIGNATURE <u>Mrs. Clark Handell</u>			

USE BLACK INK OR TYPEWRITER RIBBON

Permit issued 7/29/62

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,

by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed John E. Rupp

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.