

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-033864

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 1152

STATE FILE NUMBER

FILED OCT 15 1962

| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | | |
|---|---|---|--|--------------------------------------|
| a. COUNTY Buchanan | | a. STATE Missouri b. COUNTY Jackson | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph | | Length of stay in lb 30 yr. 6 mo. | c. CITY OR TOWN Kansas City | |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hospital #2 | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 3226 East 12th | |
| 3. NAME OF DECEASED (Type or print) First Mabel Middle Stone Last Stone | | | 4. DATE OF DEATH Month Oct. Day 8, Year 1962 | |
| 5. SEX female | 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 9/24/1879 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) labor clerk | 10b. KIND OF BUSINESS OR INDUSTRY Candy Manufacturing | 11. BIRTHPLACE (City and state or country) Warrensburg, Mo. | 12. CITIZEN OF WHAT COUNTRY USA | |
| 13a. FATHER'S NAME James H. Stone | | 13b. MOTHER'S MAIDEN NAME Corinna Critchfield | 14. NAME OF HUSBAND OR WIFE Solomn S. Monosson, MD. St. Joseph, Mo. | |
| 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. none | 17. INFORMANT Solomn S. Monosson, MD. 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) Coronary artery thrombosis DUE TO (b) arteriosclerotic heart disease DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH unknown | |
| 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 _____ to _____ and last saw her/him alive on _____ Death occurred at 5:15 a. m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | |
| 22a. SIGNATURE (Degree or title) <i>C. Swi<th>th</th> M.D.</i> | | th | 22b. ADDRESS State Hospital #2, St. Joseph, Mo. | 22c. DATE SIGNED 10/8/1962 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) removal | 23b. DATE 10/9/1962 | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City, town, or county) (State) Kirksville Mo. | |
| 24. FUNERAL DIRECTOR <i>Heaton Bowman</i> | | ADDRESS St. Joseph, Mo. | 25. DATE RECD. BY LOCAL REG. Oct. 9, 1962 | |
| | | 26. REGISTRAR'S SIGNATURE <i>Mrs. Clark Goodell</i> | | |

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

VS 300
Rev. 4/59

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Permit issued 10/19/62

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,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed William Spuehling

Licensed Embalmer No. 4585

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.