

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

62-037689

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

042

1000

1162

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

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

FILED OCT 17 1962

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in 1b unknown	c. CITY OR TOWN St. Joseph Denver Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR near intersection INSTITUTION 5th & Jackson		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 5th & Jackson Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) WILLIAM T. DICKEY			4. DATE OF DEATH Month Day Year Oct. 12, 1962	
5. SEX male	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (last birthday) 48
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Columbus, Miss.	12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME Milton A. Dickey		13b. MOTHER'S MAIDEN NAME Ola May Kehoe		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give way or dates of service) yes		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Melton Dickey, 7422 84th Ave. Hyattsville, Maryland	

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) massive intra-abdominal hemorrhage			3 hours
DUE TO (b) Rupture of liver			1 hour
DUE TO (c) Due to stamp by assailant			at once
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 checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) During a fight	
20c. TIME OF INJURY Hour Month, Day, Year 630 10/12/62		20d. PLACE OF INJURY (If in or about home, farm, factory, street, office bldg., etc.) near intersection 5th & Jackson St. St. Joseph Buchanan Co. Mo	
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20f. CITY, TOWN, OR LOCATION St. Joseph Buchanan Co. Mo	

21. I attended the deceased from **Unusual body** and last saw him **live on Oct 12 1962**
Death occurred at **930 p.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) S.E. Meloney M.D. Coroner		22b. ADDRESS		22c. DATE SIGNED 10/15/62
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 10/18/1962	23c. NAME OF CEMETERY OR CREMATORY Ft. Leavenworth Nat'l Cem.	23d. LOCATION (City, town, or county) Leavenworth	(State) Kansas

24. FUNERAL DIRECTOR Hester-Bowman	ADDRESS St. Joseph, Mo.	25. DATE RECD. BY LOCAL REG. Oct. 16, 1962	26. REGISTRAR'S SIGNATURE Wm. Clark Woodell
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(Licensed Embalmer's Statement on Reverse Side)

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

BY AFFIDAVIT OF

S.E. Meloney, M.D. CERTIFICATION

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

OCT 18 1962

Permit issued 10/16/62

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 Eugene Wood

Licensed Embalmer No. 3204
P. O. Address 319 So 12th 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.