

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-037707

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 1192

STATE FILE NUMBER

VS 300
Rev. 4/59

5117

25117

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF M.H. Christ, M.D. MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>		Length of stay in 1b <u>Life</u>	c. CITY OR TOWN <u>St. Joseph</u>		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>Methodist Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>104 E. Valley St.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Mary</u> Last <u>Inscho</u>			4. DATE OF DEATH Month <u>October</u> Day <u>12</u> Year <u>1962</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>June 4, 1893</u>	9. AGE (last birthday) <u>69</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attendant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State Hospital # 2</u>	11. BIRTHPLACE (City and state or country) <u>St. Joseph, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Christian Hoffman</u>		13b. MOTHER'S MAIDEN NAME <u>Rachel Halner</u>		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) <u>No</u>		16. SOCIAL SECURITY NO. [Redacted]	17. INFORMANT Address <u>Mrs. Gene Hirtler 879 Court St.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease with</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Congestive Failure</u> DUE TO (c) <u>Diabetes Mellitus with Acidosis</u>					INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Amputation Foot due to Arteriosclerosis</u>					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 checked="" 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 <u>1957</u> to <u>Oct 12, 1962</u> and last saw her <u>alive</u> on <u>Oct 12, 1962</u> Death occurred at <u>11:05 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <u>M.H. Christ, M.D.</u> (Degree or title)		22b. ADDRESS <u>6106 King Hill Ave</u>		22c. DATE SIGNED <u>10-16-62</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Oct. 15, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>	23d. LOCATION (City, town, or county) <u>St. Joseph, Mo.</u>	(State)		
24. FUNERAL DIRECTOR <u>Clark Funeral Home</u> ADDRESS <u>St. Joseph, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Oct. 24, 1962</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Clark Goodell</u>			

USE BLACK INK OR TYPEWRITER RIBBON

Permit issued 10/15/62

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 Earl A. Clark

Licensed Embalmer No. 4235

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.