

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-041719

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 1340 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED DEC 5 1962

VS 300
Rev. 4/59

1 5117
2 5117
3 2
4 1
5 1
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7 1
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9 94200
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12 2-0
13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

| | | | |
|--|---|--|---|
| 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 4oyrs | 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 Mo. Methodist Hospital | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 2126 So 7th Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Alice Middle Last Phay | | | 4. DATE OF DEATH Month Nov. Day 27 Year 1962 |
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH Aug. 29, 1913 AGE (last birthday) 49 |
| 10a. USUAL OCCUPATION (Give kind of work done in last 12 months, even if retired) Housekeeper | | 10b. KIND OF BUSINESS OR INDUSTRY Home | 11. BIRTHPLACE (City and state or country) Elwood Kansas |
| 13a. FATHER'S NAME Charles Fattig | | 13b. MOTHER'S MAIDEN NAME Martha Cline | 14. NAME OF HUSBAND OR WIFE Oceola Phay |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. none | 17. INFORMANT Oceola Phay, St. Joseph, Mo Address |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion | | | INTERVAL BETWEEN ONSET AND DEATH 1 1/2 days |
| DUE TO (b) Arteriosclerotic Heart Disease | | | 8 yrs |
| DUE TO (c) Arteriosclerosis | | | 8 yrs |
| 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. 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 <u>3/17/53</u> , to <u>11/27/62</u> and last saw her/him alive on <u>11/27/62</u> . Death occurred at <u>5:30 P.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <i>Sharon E. Waggoner M.D.</i> | | 22b. ADDRESS 301 Illinois Ave St. Joseph, Missouri | 22c. DATE SIGNED 11/30/62 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 12/1/62 | 23c. NAME OF CEMETERY OR CREMATORY Green Cemetery | 23d. LOCATION (City, town, or county) (State) St. Joseph, Mo |
| 24. FUNERAL DIRECTOR <i>[Signature]</i> | ADDRESS St. Joseph, Mo | 25. DATE RECD. BY LOCAL REG. Dec. 3, 1962 | 26. REGISTRAR'S SIGNATURE <i>Mrs. Clark Goodell</i> |

USE BLACK INK OR TYPEWRITER RIBBON

S.E. Waggoner, M.D. MEDICAL CERTIFICATION

DEC 19 1962

Permit issued 11/27/62

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,

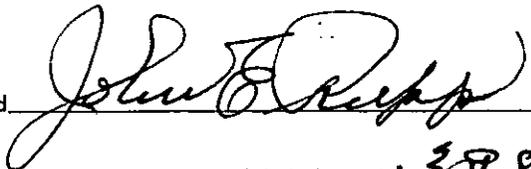
~~by~~ _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____



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.