

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-045938
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 1444

FILED DEC 26 1962

VS 300
Rev. 4/59

15117
25117

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12 93-0

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF:

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF G.S. Waraich, M.D. CERTIFICATION

USE BLACK INK OR TYPEWRITER RIBBON

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 Life in Co.	c. CITY OR TOWN Gower
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) Rural
3. NAME OF DECEASED (Type or print) First FRANK Middle DAVIS Last CONNETT		4. DATE OF DEATH Month December Day 21 Year 1962	
5. SEX Male	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 Jan. 25, 1895
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm	9. AGE (last birthday) 67
11a. FATHER'S NAME S. S. Connett		11b. MOTHER'S MAIDEN NAME Laura Brown	
12a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		12b. SOCIAL SECURITY NO. <input type="checkbox"/>	
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME	
14a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		14b. SOCIAL SECURITY NO. <input type="checkbox"/>	
15. CAUSE OF DEATH (Enter only one cause per line if PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atherosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH Unknown	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		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	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) dehydration and emaciation; decubitus ulcers, lumbago		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 Sept. 24, 1962 to Dec. 21, 1962 and last saw ^{him} alive on Dec. 21, 1962 Death occurred at 6:20 PM on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) G.S. Waraich M.D.		22b. ADDRESS State Hospital No 2 St. Joseph, Mo.	
22c. DATE SIGNED 21 Dec 62		22d. CITY, TOWN, OR COUNTY (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Dec. 24, 1962	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	
23d. LOCATION (City, town, or county) St. Joseph, Missouri		23e. DATE RECD. BY LOCAL REG. Dec. 24, 1962	
24. FUNERAL DIRECTOR Meierhoffer-Fleeman Inc., St. Joseph, Mo.		26. REGISTRAR'S SIGNATURE Mrs. Clara Goodell	

DEPARTMENT OF HEALTH, DIVISION OF VITAL RECORDS

REGISTRATION

Include limits

Yes No

Reside on form

Yes No

Day

DATE OF DEATH

Month Day Year

TIME OF DEATH

Hour Minute

PLACE OF DEATH

Home Hospital Other

CAUSE OF DEATH

Interval between onset and death

Hours Minutes

Place of death

Time of death

Age at death

Sex

Color

Marital status

Occupation

Education

Religion

Other

Signature of decedent

Signature of witness

Signature of registrar

Signature of physician

Signature of funeral director

Signature of other

Signature of

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 Raymond H. Moor

Licensed Embalmer No. 5147

P. O. Address St Joseph Ho.

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.

Permit issued 12/24/62