

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=63-015069

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 485 STATE FILE NUMBER

FILED APR 15 1963

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Buchanan</b> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b> Length of stay in 1b <b>52 Yrs</b> c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>813 Parker St.</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b> c. CITY OR TOWN <b>St. Joseph</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <b>118 1/2 No. 5th</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				
<b>3. NAME OF DECEASED</b> (Type or print) First <b>ELSIE</b> Middle Last <b>SCHAFF</b>		<b>4. DATE OF DEATH</b> Month <b>April</b> Day <b>13</b> Year <b>1963</b>				
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. Married</b> <input type="checkbox"/> Never Married <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>4-20-1887</b>	<b>9. AGE (last birthday)</b> <b>75</b>	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	<b>IF UNDER 24 HR</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Household Executive</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Gentry Co. Mo</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>USA</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>USA</b>
<b>13a. FATHER'S NAME</b> <b>Harrison Caton</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>Mary Ellen Carpenter</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>Pete</b>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				<b>17. INFORMANT</b> Address <b>Mrs James Handley St. Joseph, Mo.</b>		
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Cancer of lung</b> DUE TO (b) <b>Cancer of colon</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <b>4 wks</b> <b>unknown</b>
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		
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)				
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. Month, Day, Year						
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE		
<b>21. I attended the deceased from</b> <b>20 October 1962</b> and last saw her alive on <b>13 April 1963</b> and last saw him alive on <b>8 April 1963</b> Death occurred at <b>6:00 a.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.						
<b>22a. SIGNATURE</b> (Degree or title) <b>H. O. Curran M.D.</b>			<b>22b. ADDRESS</b> <b>1302 Faxon St. Joseph Mo</b>		<b>22c. DATE SIGNED</b> <b>13 April 1963</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>	<b>23b. DATE</b> <b>Apr. 16, 1963</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Mt. Olivet Cemetery</b>		<b>23d. LOCATION</b> (City, town, or county) (State) <b>St. Joseph, Mo.</b>		
<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>H.O. Sidenfaden &amp; Son St. Joseph, Mo.</b>			<b>25. DATE RECD. BY LOCAL REG.</b> <b>April 15, 1963</b>	<b>26. REGISTRAR'S SIGNATURE</b> <b>Mrs. Clark Goodell</b>		

BY AFFIDAVIT OF H.A. CURRAN, M.D. CERTIFICATION

DOCUMENT

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59  
  
15117  
25117  
  
3  
4 1  
5 2  
6  
7 0  
8 2  
9 153.8  
10  
11  
12 90.0  
13 1-0

USE BLACK INK OR TYPEWRITER RIBBON

Resubmitted 4-15-63

**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: Robert H. Gaylor  
Licensed Embalmer No. 3308

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.