RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS OCT 3 1960 042

-60-033888
STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. 1000 Registrar's No. 1004

NDED

1. PLACE OF DEATH
a. COUNTY: Buchanan
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Joseph
Length of stay in 1b: 4/20/1955
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: State Hospital # 2
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Jackson
c. CITY OR TOWN: Kansas City
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 3207 Olive Street
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First RAY Middle LOWER Last HECTOR

4. DATE OF DEATH: Month September Day 24, Year 1960

5. SEX: Male
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 1/11/1905
9. AGE (last birthday): 55 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HR: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): Maysville, Missouri
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Louis Hector
13b. MOTHER'S MAIDEN NAME: Maude Walters
14. NAME OF ~~HUSBAND OR~~ WIFE: Velme Hector

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 500-07-1056
17. INFORMANT Address: Hospital's Record, St. Joseph, Mo.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Cardio - Vascular Syphilis
DUE TO (c): C.B.S. Assoc. with C.N.S. Syphilis
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)

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

MEDICAL CERTIFICATION

21. I attended the deceased from 9-23-1960, to 9-24-1960 and last saw her/him alive on 9-23-1960
Death occurred at 9-24-1960 2:34 A.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Mohammed Tahir M.D.
22b. ADDRESS: State Hospital #2
22c. DATE SIGNED: 9-24-60

BY AFFIDAVIT OF M. Tahir, M.D.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 9-26-1960
23c. NAME OF CEMETERY OR CREMATORY: Memorial Park Cemetery
23d. LOCATION (City, town, or county) (State): St. Joseph, Missouri

24. FUNERAL DIRECTOR ADDRESS: Stamey Funeral Home St. Joseph, Mo.
(GAS)
25. DATE RECD. BY LOCAL REG.: Sept 26, 1960
26. REGISTRAR'S SIGNATURE: Mrs. Clark Goodell

(Licensed Embalmer's Statement on Reverse Side)

OCT 8 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed Charles E Bennett
Signature of Student Embalmer

Licensed Embalmer No. 4677

P. O. Address St Joseph

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co
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.