

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40788

State File No.

FILED DEC 31 1951

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 1314

1. PLACE OF DEATH a. COUNTY Buchanan <u>01A</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence-before-admission). a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph <u>0117</u>	
c. LENGTH OF STAY (in this place) Life		d. STREET ADDRESS (If rural, give location) 919 W. Hyde Park Ave.	
d. FULL NAME OF HOSPITAL OR INSTITUTION 919 W Hyde Park Ave.			

3. NAME OF DECEASED (Type or Print)	a. (First) FRENANDO	b. (Middle) FRED	c. (Last) WILLIS	4. DATE OF DEATH (Month) (Day) (Year)
				12 19 1951

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 7-4-1874	9. AGE (In years) (months) (days) (hours) (min.) 77
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10a. USUAL OCCUPATION (Give kind of work (do during most of working life, even if retired)) Farmer	10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (State or foreign country) Indiana	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME John D. Willis	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Norma Willis
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. not given	17. INFORMANT'S SIGNATURE OR NAME Mrs. Marion Kirk, St. Joseph, Mo.	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis		1.5 hrs.
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Coronary disease DUE TO (c)		1 yr.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 4201	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) No	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 10/4/51, to 11-10, 1951, that I last saw the deceased alive on 11/10, 1951, and that death occurred at 9:30A m., from the causes and on the date stated above.

23a. SIGNATURE <u>H. A. Allman M.D.</u> (Degree or title)	23b. ADDRESS <u>W. S. Brady</u>	23c. DATE SIGNED <u>11/11/51</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 12-22-1951	24c. NAME OF CEMETERY OR CREMATORY Memorial Park	24d. LOCATION (City, town, or county) (State) St. Joseph, Missouri
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DATE REC'D BY LOCAL REG. Dec 26, 1951	REGISTRAR'S SIGNATURE <u>Carl C. Cash</u>	446	25. FUNERAL DIRECTOR'S SIGNATURE <u>W. S. Brady</u> ADDRESS St. Joseph, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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~~

.....
working under my personal supervision.

Signed.....
Student Embalmer

..... Student Embalmer No.
Signed *John E. Riepp*
Licensed Embalmer No. *3986*
P. O. Address *H. Joseph, Ill.*

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 this body is not embalmed, fact should be so stated above.