

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34229

State File No.

S. No. 300
V. 10.48
OCT 27 1952

BIRTH NO. _____		REG. DIST. NO. <u>42</u>		PRIMARY REG. DIST. NO. <u>1000</u>		Registrar's No. <u>1107</u>	
1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>			
b. CITY OR TOWN <u>St. Joseph</u>		c. LENGTH OF STAY (in this place) <u>9 years</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u> <u>0117</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>3111 Lafayette St.</u>				d. STREET ADDRESS (If rural, give location) <u>3111 Lafayette St.</u> <u>0</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Archie</u>		b. (Middle) <u>L.</u>		c. (Last) <u>Decker</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>October 17, 1952</u>	
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>December 21, 1875</u>	
9. AGE (In years last birthday) <u>76</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ret. groceryman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>grocery company</u>		11. BIRTHPLACE (State or foreign country) <u>Missouri</u> <u>0</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>unk.</u>		13b. MOTHER'S MAIDEN NAME <u>unk.</u>		14. NAME OF HUSBAND OR WIFE <u>Fannie B.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>unk.</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Fannie Decker, 3111 Lafayette, St. Joseph</u>			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary occlusion</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Coronary thrombosis</u> DUE TO (c) <u>arteriosclerosis</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>over exertion</u>					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>none</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>4201</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 17, 1952</u> , to <u>Oct 17, 1952</u> , that I last saw the deceased alive on <u>Oct 17, 1952</u> and that death occurred at <u>2:30am</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Sharon E. Waggoner, M.D.</u>				23b. ADDRESS <u>301 Illinois Ave</u>		23c. DATE SIGNED <u>Oct 19, 1952</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		24b. DATE <u>10/20/1952</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Troy, Kansas</u>	
DATE REC'D BY LOCAL REG. <u>Oct 23, 1952</u>		REGISTRAR'S SIGNATURE <u>Carl C. Cash</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Hester-Brown Funeral Home</u>		ADDRESS <u>S. F. 900th St. Mo.</u>	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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
Student Embalmer

Signed *W E Johnston*

Licensed Embalmer No. *4791*

P. O. Address *319 So 10 St Wash DC*

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.