

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **37674**

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 1240

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, 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) 24 Yrs		d. STREET ADDRESS (If rural, give location) 2301-1/2 Goff Avenue	
d. FULL NAME OF HOSPITAL OR INSTITUTION Methodist Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) THELMA b. (Middle) LORENE c. (Last) BOATWRIGHT			4. DATE OF DEATH (Month) (Day) (Year) Nov. 22 1952		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH Feb. 18, 1905			9. AGE (In years last birthday) 47		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Home			11. BIRTHPLACE (State or foreign country) Atchison, Kansas		12. CITIZEN OF WHAT COUNTRY? U S A

13a. FATHER'S NAME Alanzo Smith		13b. MOTHER'S MAIDEN NAME Marietta Sunday		14. NAME OF HUSBAND OR WIFE Chapman Boatwright	
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. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Chapman Boatwright St. Joseph, Mo.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH 20 hrs.	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Angina Pectoris			
		DUE TO (c) _____			
		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 4-201		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT (Specify) SUICIDE HOMICIDE		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
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?	

22. I hereby certify that I attended the deceased from 12-20, 1952, to 11-22, 1952, that I last saw the deceased alive on 11-21, 1952, and that death occurred at 1:45 P.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Wm B Boatwright		23b. ADDRESS 316 North City		23c. DATE SIGNED 11-24-52	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Nov. 24, 1952		24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	
		24d. LOCATION (City, town, or county) (State) St. Joseph, Missouri			

DATE REC'D BY LOCAL REG. Dec. 1, 1952		REGISTRAR'S SIGNATURE Carl C. Cash		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Stammy Funeral Home St. Joseph, Mo	
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(Licensed Embalmer's Statement on Reverse Side)

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 Emil Clark

Licensed Embalmer No. 4238

P. O. Address Stoughton, Ma

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.