

FILED AUG 31 1953

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **27776**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 905

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Mo. Metho. Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>2522 Mulberry St.</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>CLAUDE</u> b. (Middle) <u>POWELL</u> c. (Last) <u>FORDYCE</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>August 18, 1953</u>
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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>March 6, 1883</u>	9. AGE (In years last birthday) <u>70</u>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR Min.
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10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <u>Physician</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>M.D. Eye, Ear-Nose &amp; Throat</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>McLane, Illinois</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Charles Fordyce</u>	13b. MOTHER'S MAIDEN NAME <u>Marie Gray</u>	14. NAME OF HUSBAND OR WIFE <u>Dora M. Fordyce</u>
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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>112-03-9409</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs Dora M. Fordyce</u>	ADDRESS <u>St. Joseph, Mo</u>
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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		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>
	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute Myocardial infarction</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
11. 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 <u>4201</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from Aug. 11, 1953 to Aug 18, 1953, that I last saw the deceased alive on Aug 17, 1953, and that death occurred at 6:15A.m., from the causes and on the date stated above.

23a. SIGNATURE <u>[Signature]</u>	(Degree or title) 23b. ADDRESS <u>902 Edmond St., City</u>	23c. DATE SIGNED <u>8-19-53</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>Aug. 20, 1953</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Steele Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Falls City, Nebr.</u>
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DATE REC'D BY LOCAL REG <u>Aug 24, 1953</u>	REGISTRAR'S SIGNATURE <u>Kathryn M. Allison</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>William McHugh</u>	ADDRESS <u>St. Joseph, Mo</u>
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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

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed

*Raymond H. Morehead*

Licensed Embalmer No.

4413

P. O. Address

*Joseph M.*

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.