

FILED DEC 7 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38330

State File No.

BIRTH NO. _____		REG. DIST. NO. <u>42</u>		PRIMARY REG. DIST. NO. <u>1000</u>		Registrar's No. <u>1240</u>	
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. LENGTH OF STAY (In this place) <u>13 years</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph,</u>		0117 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>2329 S. 16th St.</u>				d. STREET ADDRESS (If rural, give location) <u>2329 S. 16th St.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Coverdale</u>			b. (Middle) <u>Smith</u>		c. (Last) <u>Rennison</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 23, 1953</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>June 3, 1870</u>		9. AGE (In years last birthday) <u>83</u>	10. UNDER 1 YEAR Months _____ Days _____	11. UNDER 5 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ret. minister</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Threlkeld, England</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Matilda Aucia Rennison</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>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. C. S. Rennison, 2329 S. 16th, St. Joseph, Mo.</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, asphyxia, 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>Arteriosclerosis - Generalized</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>10 yrs.</u>
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				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) _____		4201	
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>December, 1946</u> , to <u>Nov 23, 1953</u> , that I last saw the deceased alive on <u>Nov 23, 1953</u> , and that death occurred at <u>9:00p. m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Coverdale W. Allison M.D.</u>				23b. ADDRESS <u>570 Francis Ave. St. Joseph Mo.</u>		23c. DATE SIGNED <u>24 Nov 53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>11/27/1953</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Joseph, Missouri</u>		
DATE REC'D BY LOCAL REG. <u>Dec. 1, 1953</u>		REGISTRAR'S SIGNATURE <u>Cather M. Allison</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Wheaton - Bowman Funeral Home St. Joseph, Mo.</u>			

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 James P. Hawkins

Licensed Embalmer No. 4536

P. O. Address 319 So 10th St. Jax

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.