

FILED JUN 21 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 17927

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 618

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	
c. LENGTH OF STAY (in this place) Life		d. STREET ADDRESS (If rural, give location) 2920 Olive St.	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph's Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) HAROLD b. (Middle) WILLIAM c. (Last) FODDY SR.			4. DATE OF DEATH (Month) (Day) (Year) June 11 1954		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH July 31, 1902		9. AGE (In years last birthday) 51		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman	
11. BIRTHPLACE (State or foreign country) St. Joseph, Missouri		12. CITIZEN OF WHAT COUNTRY? U S A		10b. KIND OF BUSINESS OR INDUSTRY Retail Store	

13a. FATHER'S NAME Frank Foddy		13b. MOTHER'S MAIDEN NAME Martha Marche		14. NAME OF HUSBAND OR WIFE Juanita Foddy	
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. 491-09-1030		17. INFORMANT'S SIGNATURE OR NAME Mrs. Juanita Foddy	
				ADDRESS St. Joseph, Mo.	

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, asthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 15 days
	ANTECEDENT CAUSES Myocardial Infarct. Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ 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		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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)	
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 5-30, 1954 to 6-11, 1954, that I last saw the deceased alive on 6-11, 1954, and that death occurred at 8:15 P.M., from the causes and on the date stated above.

23a. SIGNATURE <i>E. J. Sherattus md</i> (Degree or title)		23b. ADDRESS Doctor, Beeg City		23c. DATE SIGNED 6-12-54	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE June 14, 1954		24c. NAME OF CEMETERY OR CREMATORY Ashland Cemetery	
				24d. LOCATION (City, town, or county) (State) St. Joseph Missouri	

DATE REC'D BY LOCAL REG. June 17, 1954		REGISTRAR'S SIGNATURE <i>Ether M. Allison</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Stoney Funeral Home</i> ADDRESS <i>St. Joseph, Mo</i>	
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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.

Student Embalmer No.....

Signed.....
Student Embalmer

Signed.....

John Roy Stanley

Licensed Embalmer No. *2435*

P. O. Address..... *St. Joseph*

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.