

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22110

State File No.

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 805

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Kansas</u> b. COUNTY <u>Doniphan</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>6 weeks</u>	c. CITY OR TOWN <u>White Cloud</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Missouri Methodist Hospital</u>			e. STREET ADDRESS (If rural, give location) <u>815⁰ 8</u>		
3. NAME OF DECEASED (Type or Print) a. (First) <u>Raymond</u> b. (Middle) _____ c. (Last) <u>Breeze</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>July 14, 1954</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 26, 1899</u>	9. AGE (in years last birthday) <u>55</u>	IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 2 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and State or Foreign Country) <u>Urbana, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>John Breeze</u>		13b. MOTHER'S MAIDEN NAME <u>Irene McCall</u>		14. NAME OF HUSBAND OR WIFE <u>Gladys</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>513-03-9203</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Gladys Breeze, White Cloud, Kansas</u> ADDRESS _____		
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>		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hrs</u>
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>none known</u>			DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>none</u>			_____		
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>1201</u>	
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) (Min.) _____		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>7-14-54</u> to <u>7-14-54</u> , that I last saw the deceased alive on <u>7-14-54</u> , and that death occurred at <u>2:00 p.</u> m., from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) <u>Ed Grant M.D.</u>			23b. ADDRESS <u>St. Joseph, Mo</u>		23c. DATE SIGNED <u>7-16-54</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>7/14/1954</u>	24c. NAME OF CEMETERY OR CREMATORY _____	24d. LOCATION (City, town, or county) (State) <u>Highland, Kansas</u>	
DATE REC'D BY LOCAL REG. <u>July 21, 1954</u>	REGISTRAR'S SIGNATURE <u>Kathleen M. Allison</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>485 Weston Swanson</u>		ADDRESS <u>St. Joseph, Mo</u>

(Licensed Embalmer's Statement on Reverse Side)

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

AUG 30 1937

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
Signature of Student Embalmer

Signed *William Spading*

Licensed Embalmer No. *4535*

P. O. Address *245 10th St. N.W.*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.