

25407

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED AUG 22 1955

BIRTH NO. _____		REG. DIST. NO. <u>42</u>		PRIMARY REG. DIST. NO. <u>1000</u>		Registrar's No. <u>883</u>			
1. PLACE OF DEATH a. COUNTY <u>Duchanan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u>				b. COUNTY <u>Jackson</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>10 4-10 7-12</u>		c. CITY OR TOWN <u>Kansas City</u>		d. 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>State Hospital No 2</u>				e. STREET ADDRESS (If rural, give location) <u>2545 Montgall</u>				<u>2325</u>	
3. NAME OF DECEASED (Type or Print)			a. (First) <u>Helen</u>			b. (Middle)			
			c. (Last) <u>Stephens</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 16 - 1955</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>		8. DATE OF BIRTH <u>May 15 1886</u>		9. AGE (In years last birthday) <u>69</u> if UNDER 1 YEAR: Months <u>3</u> Days <u>1</u> if UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (City and State or Foreign Country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>not given</u>			13b. MOTHER'S MAIDEN NAME <u>not given</u>			14. NAME OF HUSBAND OR WIFE <u>not given</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>now</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Marian Porter</u>		ADDRESS <u>2545 Montgall K.C. 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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>	
		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>Arterio sclerosis</u>							
		DUE TO (c) <u>4201</u>							
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Schizophrrenia simple type</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)					
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 <u>Jan 1</u> , 19 <u>55</u> , to <u>Aug. 16</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Aug. 16</u> , 19 <u>55</u> , and that death occurred at <u>1 A</u> m., from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>Forrest Thomas M.D.</u>				23b. ADDRESS <u>St Joseph Mo of State Hosp No 2</u>		23c. DATE SIGNED <u>8/16-55</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <u>Use as cadaver 8-18-55</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Kirksville D.O. College</u>		24d. LOCATION (City, town, or county) (State) <u>Kirksville, Missouri</u>			
DATE REC'D BY LOCAL REG. <u>Aug 18, 1955</u>		REGISTRAR'S SIGNATURE <u>Leather M. Allison</u>		25. FEMERAL DIRECTOR'S SIGNATURE <u>Leather M. Allison</u>		ADDRESS <u>St. Joseph, Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10-48

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, ~~of~~....., Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Alvin C. Boye*.....

Licensed Embalmer No. *47*.....
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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.