

8078

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

288

1000

PRIMARY REG. DIST. NO.

42

REG. DIST. NO.

FILED MAR 19 1956

No. 300

10.48

BIRTH NO. _____		REG. DIST. NO. 42		PRIMARY REG. DIST. NO. 1000		Registrar's No. 288	
1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Gentry</b>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Joseph</b>		c. LENGTH OF STAY (In this place) <b>12 Yrs</b>		c. CITY OR TOWN <b>Stanberry</b>		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 <b>State Hospital # Two</b>				e. STREET ADDRESS (If rural, give location) <b>unknown</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>Daisy</b> b. (Middle) <b>May</b> c. (Last) <b>Black</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>March 10th 1956</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>		8. DATE OF BIRTH <b>Jan. 11 1881</b>	
9. AGE (In years last birthday) <b>75 Yrs</b>		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (City and State or Foreign Country) <b>St. Joseph, Missouri.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>housework</b>		13a. FATHER'S NAME <b>John Lambert</b>		13b. MOTHER'S MAIDEN NAME <b>Claricie Clark</b>	
13c. FATHER'S NAME		13d. MOTHER'S MAIDEN NAME		14. NAME OF HUSBAND OR WIFE <b>Gradon Black</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Hospital Records at State Hosp # 2.</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Hospital Records at State Hosp # 2.</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION--					INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Myocarditis</b>		II. OTHER SIGNIFICANT CONDITIONS					<b>Chronic</b>
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES					<b>12 Yrs</b>
		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.					<b>15 Yrs.</b>
		DUE TO (b) <b>Asthma And. Bronchitis</b>					
		DUE TO (c) <b>Arteriosclerosis</b>					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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) (Min.)	
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?					
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 <b>Jan 1, 1956</b> , to <b>3-10-1956</b> , that I last saw the deceased alive on <b>3-10-1956</b> , and that death occurred at <b>5:50p</b> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>G.E. Corrine M.D.</b>				23b. ADDRESS <b>State Hospital # 2.</b>		23c. DATE SIGNED <b>3-10-1956</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>(Removal)</b>		24b. DATE <b>Mar. 13, 1956</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Anatomical Board Kirkville</b>		24d. LOCATION (City, town, or county) (State) <b>Kirkville, Missouri.</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>(Removal)</b>		24b. DATE <b>Mar. 13, 1956</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Anatomical Board Kirkville</b>		24d. LOCATION (City, town, or county) (State) <b>Kirkville, Missouri.</b>	
DATE REC'D BY LOCAL REG. <b>Mar 14, 1956</b>		REGISTRAR'S SIGNATURE <b>Eathan M. Allison</b>		25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS <b>Meierhoff &amp; Fleunert, Joseph, Mo.</b>			
DATE REC'D BY LOCAL REG. <b>Mar 14, 1956</b>		REGISTRAR'S SIGNATURE <b>Eathan M. Allison</b>		25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS <b>Meierhoff &amp; Fleunert, Joseph, Mo.</b>			

(Licensed Embalmer's Statement on Reverse Side)

This body was embalmed and removed to Kirksville College of Osteopathy and surgery. By authorization of State Hospital # Two. WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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..... *Raymond W. Mark*

Licensed Embalmer No. *44*

P. O. Address *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.