

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

76333

STATE FILE NUMBER

FILED APR 1 - 1957

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 333

| | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|---------------------------------------------------------------------------------------------------|
| 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, give TOWNSHIP only) OR TOWN St. Joseph | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN St. Joseph 0170 | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2205 Charles St. | | Length of stay in lb 68 Yrs. | d. STREET ADDRESS (If outside, give location) 2205 Charles St. | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last Amanda Bibbins | | | 4. DATE OF DEATH Month Day Year March 20, 1957 | | |
| 5. SEX 3 Female | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov. 10, 1835 | | 9. AGE (In years last birthday) 71 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | 11. BIRTHPLACE (City and state or country) Atchison, Kansas | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Henry Franklin | | | 14. MOTHER'S MAIDEN NAME Nellie (not given) | | |
| 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. None | 17. INFORMANT Address City Mrs Agnes McGaughy, 2205 Charles St. | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 MONTHS |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) GENERALIZED ATHEROSCLEROSIS. DUE TO (c) SENILITY. | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 4500 | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m. | | | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | | 20f. CITY, TOWN, OR LOCATION COUNTY STATE | |
| 21. I attended the deceased from OCT 3 - 1956, to 3/20/57 and last saw her alive on 3/20/57 Death occurred at 7:00 p m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE (Degree or title) John T. Logan M.D. | | | 22b. ADDRESS 307 Kirkpatrick Bldg St. Joe | | 22c. DATE SIGNED 3/26/57 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE March 23, 1957 | 23c. NAME OF CEMETERY OR CREMATORY City Cemetery | | 23d. LOCATION (City, town, or county) (State) St. Joseph, Missouri |
| 24. FUNERAL DIRECTOR Wm. H. Alexander, | | ADDRESS St. Joseph, Mo | | 25. DATE RECD. BY LOCAL REG. March 28, 1957 | 26. REGISTRAR'S SIGNATURE Esther M. Allison |

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Use ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Director, coroner, etc. must use only standard nomenclature in item 18. No symptoms or signs of disease in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

MEDICAL CERTIFICATION

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.....
Wm. H. Alexander

Licensed Embalmer No. *44*

P. O. Address *St. Joseph*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.. (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.