

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

7734

FILED APR 1 - 1957

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STATE FILE NUMBER

336

Registration District No. Primary Registration District No. Registrar's No.

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/ No <input checked="" type="checkbox"/>			c. CITY OR TOWN St. Joseph 0117D Inside Limits Yes/ No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Methodist Hosp. Length of stay in 1b 10 yrs			d. STREET ADDRESS (If outside, give location) 104-1/2 No. 2nd St. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First ALFRED Middle Last SAVAGE			4. DATE OF DEATH Month Mar. Day 25 Year 1957		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Sept. 19, 1881	9. AGE (In years last birthday) 75	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY General Farm	11. BIRTHPLACE (City and state or country) Dakota County Nebraska	12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME David Savage			14. MOTHER'S MAIDEN NAME Elizabeth Haney		
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. 507-05-1134	17. INFORMANT Mr. Charles R. Savage Address So. Sioux City, Nebr.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease with Broken Compensation Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Broken Compensation DUE TO (c) 					INTERVAL BETWEEN ONSET AND DEATH Unk.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 4200					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2
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 checked="" 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 3/25/57 to 3/25/57 and last saw him alive on 3/27/57 Death occurred at 7:50P m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Sam Maloney M.D.			22b. ADDRESS Kirkpatrick Bldg. St. Joseph, Missouri		22c. DATE SIGNED 3/26/57
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 3-26-57	23c. NAME OF CEMETERY OR CREMATORY Graceland Park Cemetery	23d. LOCATION (City, town, or county) (State) South Sioux City, Nebraska		
24. FUNERAL DIRECTOR Stoney Laurel Rome ADDRESS St. Joseph, Mo.		25. DATE RECD. BY LOCAL REG. March 28, 1957	26. REGISTRAR'S SIGNATURE Ethel M. Allison		

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

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Health,
Welfare
Public
Service

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

(Licensed Embalmer's Statement on Reverse Side)

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 *Charles E. Bennett*

Licensed Embalmer No. *467*

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.