

FILED APR 28 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-013361

STATE FILE NUMBER

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 431

300
-57
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1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <u>0117</u> a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Joseph</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>104 1/2 No. 2nd St.</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>104 1/2 No. 2nd St.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>TALBERT</u> Last <u>WALES</u>			4. DATE OF DEATH Month <u>April</u> Day <u>20</u> Year <u>1958</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <u>3</u> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 21, 1881</u>	9. AGE (In years last birthday) <u>76</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attendant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State Hospital</u>	11. BIRTHPLACE (City and state or country) <u>Boxford Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13a. FATHER'S NAME <u>James Wales</u>		13b. MOTHER'S MAIDEN NAME <u>Not known</u>		14. NAME OF HUSBAND OR WIFE <u>Divorced</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>500-67-2366</u>	17. INFORMANT <u>Mr. Ernest Miller</u>	Address <u>St. Joseph, Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u>					INTERVAL BETWEEN ONSET AND DEATH <u>UNK.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____					<u>331X</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					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 _____ a.m. _____ p.m.					
20d. INJURY OCCURRED WHILE AT <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 <u>UNATTENDED</u> , to _____ and last saw ^{him} <u>him</u> alive on _____ Death occurred at <u>8:00A</u> _____ m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURES <u>Assistant City Health Officer</u> <u>Journeal R. [Signature]</u>			22b. ADDRESS <u>1302 Faxon St. Joseph, Mo</u>		22c. DATE SIGNED <u>4-21-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>4-23-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Union Star Cemetery</u>	23d. LOCATION (City, town, or county) <u>Union Star Missouri</u>	(State)	
24. FUNERAL DIRECTOR <u>Stames Funeral Home</u>		ADDRESS <u>St. Joseph, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>April 22, 1958</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Clark Goodell</u>	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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. *4677*

P. O. Address *St. Joseph, Mo.*

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.