

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-012349

STATE FILE NUMBER

419

FILED MAY 4 1959

Registration District No. 042

Primary Registration District No. 1000

Registrar's No.

300
1-57

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 type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Methodist Hosp.		Length of stay in 1b 50 yrs.	d. STREET ADDRESS (If outside, give location) 1507 1/2 Penn. St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First HATTIE Middle FLORENCE Last CALVERT			4. DATE OF DEATH Month April Day 22 Year 1959		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 16, 1889		9. AGE (In years last birthday) 69
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Clay County Missouri		12. CITIZEN OF WHAT COUNTRY? U S A
13a. FATHER'S NAME Robert Gulley		13b. MOTHER'S MAIDEN NAME Not known		14. NAME OF HUSBAND OR WIFE Mr. Jasper E. Calvert	
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 Mr. Jasper E. Calvert Address 1507 1/2 Penn. St. St. Joseph, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thyro Toxic Heart Disease					INTERVAL BETWEEN ONSET AND DEATH Unknown
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Broken compensation					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 4/22/59 to 4/22/59 and last saw her ^{her} deceased alive on 4/22/59 Death occurred at 8:30 P m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>Ann W. Deary MD</i> (Degree or title)			22b. ADDRESS Social Welfare Board 10th & Olive, St. Joseph, Mo.		22c. DATE SIGNED 4/23/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-25-59	23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery		23d. LOCATION (City, town, or county) (State) St. Joseph Missouri
24. FUNERAL DIRECTOR <i>Stame Funeral Home</i> ADDRESS St. Joseph, Mo.		25. DATE RECD. BY LOCAL REG. April 24, 1959		26. REGISTRAR'S SIGNATURE <i>Mrs. Clark Goodell</i>	

All diseases in Part I must be causally related.

Dr. Owen W. D. Craig
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *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.