

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024166

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790

STATE FILE NUMBER

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

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| 1. PLACE OF DEATH a. COUNTY Buchanan | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri . COUNTY Buchanan | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph | | Length of stay in 1b 60 years | 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 #27 Ayr Lawn Add. | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) #27 Ayr Lawn Add. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|--|----------------------------------|---|--|--|---|
| 3. NAME OF DECEASED (Type or print) First FRANK Middle HOMER Last BERRY | | | 4. DATE OF DEATH Month July Day 22 Year 1959 | | |
| 5. SEX Male | 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 4/25/1881 | 9. AGE (last birthday) 78 | IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber | | 10b. KIND OF BUSINESS OR INDUSTRY Shop | 11. BIRTHPLACE (City and state or country) Jamesport, Missouri | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13a. FATHER'S NAME Unk. | | 13b. MOTHER'S MAIDEN NAME Unk. | | 14. NAME OF HUSBAND OR WIFE Opal Berry | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 488-14-9235 | 17. INFORMANT Address Opal Berry St. Joseph, Mo. | | |

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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Rectum with Metastasis | | INTERVAL BETWEEN ONSET AND DEATH 1 yr. |
| 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) | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |

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|--|---|--|--------------------------|
| 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. Month, Day, Year _____ | | | |
| 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 July 14, 1959 to July 22, 1959 and last saw him ^{him} alive on July 14, 1959 Death occurred at 2:30 P.M. on the date stated above, and to the best of my knowledge, from the causes stated. | | | |

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| 22a. SIGNATURE (Degree or title) Martin H. Christman | | 22b. ADDRESS 6106 King Hill Ave. | 22c. DATE SIGNED 7/27/59 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 7/25/1959 | 23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery | 23d. LOCATION (City, town, or county) (State) St. Joseph, Missouri |
| 24. FUNERAL DIRECTOR ADDRESS John Kapp St. Joseph, Mo | | 25. DATE RECD. BY LOCAL REG. Aug. 6, 1959 | 26. REGISTRAR'S SIGNATURE Wm. Clark Handell |

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF M.H. Christman, M.D. 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

~~or by~~ _____

Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

John E. [Signature]

Licensed Embalmer No. 33986

P. O. Address St. Jose

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.