

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-005241

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STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <i>Buchanan</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo</i> b. COUNTY <i>Buchanan</i>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Joseph</i>		Length of stay in 1b <i>59yrs</i>		c. CITY OR TOWN <i>St. Joseph</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>o. Methodist Hosp</i>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <i>729 So 5th</i>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Regina</i> Middle <i>Moreland</i> Last				4. DATE OF DEATH Month <i>Feb</i> Day <i>23</i> Year <i>1960</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <i>Mar. 29, 1900</i>	9. AGE (last birthday) <i>59</i>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House keeper</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (City and state or country) <i>St. Joseph, Mo</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13a. FATHER'S NAME <i>James Head</i>			13b. MOTHER'S MAIDEN NAME <i>Agnes Hayes</i>		14. NAME OF HUSBAND OR WIFE <i>none</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>	17. INFORMANT Address <i>Anna Purdy, St. Joseph, Mo</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Renal Insufficiency</i>						INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>	
DUE TO (b) <i>Stag Horn Calculus</i>						Unk.	
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Chronic Pyelo Nephritis</i>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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 <i>12/8/53</i> to <i>2/23/60</i> and last saw her alive on <i>2/22/60</i> Death occurred at <i>6:50 P.M.</i> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <i>Anna W. Craig MD</i>			22b. ADDRESS <i>Social Welfare Board 10th & Olive, St. Joseph, Mo.</i>		22c. DATE SIGNED <i>2/24/60</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <i>2/27/60</i>	23c. NAME OF CEMETERY OR CREMATORY <i>St. Olivet Cemetery</i>		23d. LOCATION (City, town, or county), (State) <i>St. Joseph, Mo</i>			
24. FUNERAL DIRECTOR <i>John Rupp</i>		ADDRESS <i>St. Joseph,</i>		25. DATE RECD. BY LOCAL REG. <i>Feb. 27, 1960</i>		26. REGISTRAR'S SIGNATURE <i>Mrs. Clark Standell</i>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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. Rupp

Licensed Embalmer No. 7986

P. O. Address St. Joseph

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.