

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-010041

FILED VS APR 11 1960

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425

STATE FILE NUMBER

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

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|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | | | |
| a. COUNTY Buchanan | | b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph | | Length of stay in 1b 2 years | | c. CITY OR TOWN Liberty | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hospital #2 | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS --- | | (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | | | | 4. DATE OF DEATH | | | |
| First Elizabeth | | Middle | | Last Yates | | April 3 1960 | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 11-27-1875 | |
| 9. AGE (last birthday) 75 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | | 11. BIRTHPLACE (City and state or country) Kearney, Missouri | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13a. FATHER'S NAME James A. Yates | | 13b. MOTHER'S MAIDEN NAME Catherine Martin | | 14. NAME OF HUSBAND OR WIFE ---- | | | |
| 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. unknown | | 17. INFORMANT Address Records, State Hospital #2, St. Joseph | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) Cerebral Thrombosis | | | | | | 3 days | |
| DUE TO (b) Cerebro-Vascular Accident | | | | | | 3 days | |
| DUE TO (c) Cerebral Arteriosclerosis | | | | | | | |
| 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 | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 April 3, 1960 to April 3, 1960 and last saw her alive on April 3, 1960 | | | | Death occurred at 11:20p April 3, 1960 m on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) M. Chamonal, M.D. | | | | 22b. ADDRESS State Hospital #2, St. Joseph | | 22c. DATE SIGNED 4-3-60 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE April 4, 1960 | | 23c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery | | 23d. LOCATION (City, town, or county) (State) Liberty Missouri | |
| 24. FUNERAL DIRECTOR ADDRESS Tyler-Pasley --- Liberty, Mo | | | | 25. DATE RECD. BY LOCAL REG. April 4, 1960 | | 26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell | |

DOCUMENT

M. Chamonal, M.D. 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 _____

Licensed Embalmer No. 4534

P. O. Address Liberty 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.