

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-014243

FILED VS APR 18 1960

042

1000

450

STATE FILE NUMBER

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

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		Length of stay in 1b 51 years	c. CITY OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION Goforth Nursing Home		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 3102 Seneca St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CARRIE Middle LEE Last COONS			4. DATE OF DEATH Month April Day 10 Year 1960			
5. SEX female	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1/28/1876	9. AGE (last birthday) 84	IF UNDER 1 YEAR Months _____ Days _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (City and state or country) Camden Point, Mo.		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Edward Fairhurst		13b. MOTHER'S MAIDEN NAME Lucy Cox		14. NAME OF HUSBAND OR WIFE Edwin		
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 Clinton Coons, Highway #71, 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) Cerebral Hemorrhage					INTERVAL BETWEEN ONSET AND DEATH 4 days	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Thyfestension arterial					14 years	
DUE TO (c) _____					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	
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.		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 4-5-60 to 4-10-60 and last saw her him alive on 4-9-60 Death occurred at 2:17p. m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) R. L. Senne MD			22b. ADDRESS 223 D 9th St. Joseph, Mo		22c. DATE SIGNED 4-12-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 4/13/1960	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery		23d. LOCATION (City, town, or county) (State) St. Joseph Mo.		
24. FUNERAL DIRECTOR Heaton-Bauman		ADDRESS St. Joseph, Mo.	25. DATE RECD. BY LOCAL REG. April 14, 1960	26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell		

DOCUMENT

HL. Senne, 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 E. L. Gibson

Licensed Embalmer No. 4137

P. O. Address Excelsior Springs

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.