

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-014311

FILED VS. APR. 25 1960 042

Primary Registration District No. 1000 Registrar's No. 466

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY Buchanan b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph Length of stay in 1b 10 years 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"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan c. CITY OR TOWN St. Joseph Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) 414 East Missouri Ave Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lena Middle Erma Last Simmons			4. DATE OF DEATH Month April Day 13 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 Dec. 12, 1898	9. AGE (last birthday) 61	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (City and state or country) Bethany, Missouri.		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME John Rice			13b. MOTHER'S MAIDEN NAME Anna Bell Dart		14. NAME OF HUSBAND OR WIFE Carl F. Simmons		
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 Mrs. Keith Bingman Address 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) Hypostatic pneumonia DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH Unknown	
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 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 _____ Month, Day, Year _____ a.m. _____ p.m. _____		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 13, 1960 to Apr. 13, 1960 and last saw her/him live on Apr. 13, 1960 Death occurred at 3:45 P. m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <i>R.P. Price M.D.</i> M.D.			22b. ADDRESS State Hospital #2 St. Joseph, Mo.			22c. DATE SIGNED 4/13/60.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Apr. 14, 1960	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery		23d. LOCATION (City, town, or county) (State) St. Joseph, Missouri.		
24. FUNERAL DIRECTOR <i>Wm. C. ...</i> St. Joseph, Mo.			25. DATE RECD. BY LOCAL REG. April 18, 1960		26. REGISTRAR'S SIGNATURE <i>Wm. Clark Goodell</i>		

DOCUMENT

BY AFFIDAVIT OF MEDICAL CERTIFICATION P.P. Price, M.D.

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 Albert C. Harrison

Licensed Embalmer No. 3258

P. O. Address H. Jones

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.