

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-025978

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Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 800 STATE FILE NUMBER

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|--|--|--|---|--|--|--|--|
| 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 Lifetime c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION DOA Mo. Meth. Hospital 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) 2005 Holman St. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last William Porter Way | | | | 4. DATE OF DEATH Month Day Year July 21, 1960. | | | |
| 5. SEX Male | 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 Mar. 9, 1881 | 9. AGE (last birthday) 79 | IF UNDER 1 YEAR Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Wyeth & Co. | | 10b. KIND OF BUSINESS OR INDUSTRY Wholesale Hardware Co. | | 11. BIRTHPLACE (City and state or country) Kansas. 12. CITIZEN OF WHAT COUNTRY USA | | | |
| 13a. FATHER'S NAME Unknown | | 13b. MOTHER'S MAIDEN NAME Hannah Howard | | 14. NAME OF HUSBAND OR WIFE Araminta Way | | | |
| 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. 491-09-2995 | | 17. INFORMANT Address James Welsh 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) <i>Probably acute myocardial infarction</i> DUE TO (b) <i>arteriosclerotic heart disease</i> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | INTERVAL BETWEEN ONSET AND DEATH <i>minutes</i> | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>congestive Cardiac Failure</i> | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N. <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 | | 20g. COUNTY STATE | | | |
| 21. I attended the deceased from <i>6/13/57</i> to <i>7/21/60</i> and last saw him alive on <i>6/27/60</i> Death occurred at <i>8:00</i> p.m. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Degree or title) <i>Donald J. Stollard, M.D.</i> | | | 22b. ADDRESS <i>902 Edmund St.</i> | | 22c. DATE SIGNED <i>7/25/60</i> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE July 23, 1960 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery | | | |
| 23d. FUNERAL DIRECTOR <i>Meierhoffer-Flanagan, Inc.</i> | | 23e. ADDRESS St. Joseph, Mo. | | 23f. LOCATION (City, town, or county) (State) St. Joseph, Missouri. | | | |
| 24. DATE RECD. BY LOCAL REG. <i>July 27, 1960</i> | | | 25. REGISTRAR'S SIGNATURE <i>Mrs. Clark Woodall</i> | | | | |

DOCUMENT

DONALD J. STOLLARD, 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 Albert R. J. Darling

Licensed Embalmer No. 325

P. O. Address H. J. [unclear]

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.