

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-045219

FILED VS. DEC 27 1960 042

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STATE FILE NUMBER

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1. PLACE OF DEATH a. COUNTY <i>Buchanan</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> 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>5 yr. 10 Mo.</i>		c. CITY OR TOWN <i>St. Joseph</i> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>St. Joseph State Hospital</i>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <i>920 North 5th St.</i> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Edwin</i> Middle <i>Paul</i> Last <i>Nelson</i>			4. DATE OF DEATH Month <i>Dec.</i> Day <i>16</i> Year <i>1960</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <i>March 1, 1924</i>	9. AGE (last birthday) <i>36</i> 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) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>		11. BIRTHPLACE (City and state or country) <i>St. Joseph, Mo.</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>
13a. FATHER'S NAME <i>Unknown</i>			13b. MOTHER'S MAIDEN NAME <i>Mary Martin</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>Unknown</i>		17. INFORMANT Address <i>Records, St. Joseph State Hospital</i>		
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) <i>Coronary occlusion</i>					<i>4 hours</i>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Coronary artery arteriosclerosis</i>					<i>unknown</i>	
DUE TO (c) <i>Contrib. B Grand Mal Convulsions (3)</i>					<i>12/15/60</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Paroxysmal convulsive disorder psychosis</i>					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 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 <i>7:30 a</i> Month, Day, Year <i>Dec. 15, 1960</i>	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>Dec. 15, 1960</i> to <i>Dec. 16, 1960</i> and last saw her <i>him</i> alive on <i>Dec. 15, 1960</i> . Death occurred at <i>7:30 a</i> m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <i>Mary B. Ames, M.D.</i>			22b. ADDRESS <i>St. Joseph, Mo</i>		22c. DATE SIGNED <i>12/16/60</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE <i>Dec. 19, 1960</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Kirksville College Osteopathy</i>		23d. LOCATION (City, town, or county) (State) <i>Kirksville, Mo.</i>		
24. FUNERAL DIRECTOR ADDRESS <i>Clark Funeral Home St. Joseph, Mo.</i>		25. DATE RECD. BY LOCAL REG. <i>Dec. 19, 1960</i>		26. REGISTRAR'S SIGNATURE <i>Mrs. Clark Handell</i>		

DOCUMENT

BY AFFIDAVIT OF M.B. Ames, M.D. MEDICAL CERTIFICATION

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 Ernest A. Clark

Licensed Embalmer No. 423

P. O. Address St. Joseph

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.