

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-004665

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 193 STATE FILE NUMBER

AMENDED **FILED VS FEB 27 1961**

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| 1. PLACE OF DEATH a. COUNTY <u>Buchanan</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph, Mo.</u> | Length of stay in lb <u>65 yrs</u> | c. CITY OR TOWN <u>St. Joseph</u> | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>2721 No. 4th St.</u> | | d. STREET ADDRESS (If outside, give location) <u>2721 No. 4th St.</u> | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

3. NAME OF DECEASED (Type or print) First DAISY Middle PEARL Last SLAYBAUGH

4. DATE OF DEATH Month February Day 19 Year 1961

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|----------------------|-------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|----------------------------------|----------------------------------------------------|--------------------------------------------------|
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>5/25/76</u> | 9. AGE (last birthday) <u>84</u> | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | IF UNDER 24 HR Hours <u> </u> Min. <u> </u> |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | 11. BIRTHPLACE (City and state or country) <u>Greenwood Missouri</u> | 12. CITIZEN OF WHAT COUNTRY <u>U S A</u> |
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| 13a. FATHER'S NAME <u>Nathan White</u> | 13b. MOTHER'S MAIDEN NAME <u>Mary Mountain</u> | 14. NAME OF HUSBAND OR WIFE <u>Deceased</u> |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | 16. SOCIAL SECURITY NO. <u>D</u> | 17. INFORMANT <u>Mrs. Grace Thuman</u> Address <u>2721 No. 4th St. St. Joseph, Mo.</u> |
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:

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|--------------------------------------------------------------------------------------------|------------------------------------------------------------------------|----------------------|-----------------------------------------------|
| IMMEDIATE CAUSE (a) <u>arteriosclerosis</u> | DUE TO (b) <u>generalized arteriosclerotic subarachnoid hemorrhage</u> | DUE TO (c) <u> </u> | INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | <u>5 yrs</u> |

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| 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 |
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| 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.) |
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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 <u>St. Joseph</u> COUNTY <u>Buchanan</u> STATE <u>Missouri</u> |
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21. I attended the deceased from 9-22-56 to 2-19-61 and last saw her alive on 2-18-61

Death occurred at 3:00A m on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22. SIGNATURE <u>R. L. Magiana</u> (Degree or title) <u>MD</u> | 22b. ADDRESS <u>P.O. Bldg 216, St. Joseph Mo</u> | 22c. DATE SIGNED <u>2-20-61</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>2/21/61</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>St. Joseph Missouri</u> |
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| 24. FUNERAL DIRECTOR <u>Stamper Funeral Home</u> ADDRESS <u>St. Joseph, Mo.</u> | 25. DATE RECD. BY LOCAL REG. <u>Feb. 21, 1961</u> | 26. REGISTRAR'S SIGNATURE <u>Mrs. Clara Hardell</u> |
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DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTAED OF
 DOCUMENT
 BY AFFIDAVIT OF
 R. L. Magiana, M.D. MEDICAL CERTIFICATION
 ITEM NO. SHOULD READ

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Charles E. Bennett

Licensed Embalmer No. 4677

P. O. Address St Joseph 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.