

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-012728

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 364

STATE FILE NUMBER

AMENDED

FILED APR 17 1961

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 5 years		c. CITY OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION Hillside Nursing Home 718 N. 7th St.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1120 Messanie		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ANNA Middle E. Last RAY				4. DATE OF DEATH Month April Day 6, Year 1961				
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 7/24/1877	9. AGE (last birthday) 83	IF UNDER 1 YEAR Months Days Hours Min.	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 own home		11. BIRTHPLACE (City and state or country) Gower, Mo.		12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME unknown Hambir			13b. MOTHER'S MAIDEN NAME unknown			14. NAME OF HUSBAND OR WIFE John Ray		
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. Ellen Ray, 1120 Messanie, 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) Arteriosclerotic Heart Disease							INTERVAL BETWEEN ONSET AND DEATH Known	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b)		DUE TO (c)			
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		
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 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 4/1/61 to 4/6/61 and last saw her <sup>her</sup> <sub>him</sub> alive on 4/5/61 Death occurred at 8:55 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <i>Clifton Smith M.D.</i>			22b. ADDRESS Social Welfare Board St. Joseph, Missouri		22c. DATE SIGNED 4/7/61			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 4/9/1961	23c. NAME OF CEMETERY OR CREMATORY Allen Cemetery		23d. LOCATION (City, town, or county) (State) Gower, Missouri				
24. FUNERAL DIRECTOR <i>Nestor Bowman</i>		ADDRESS St. Joseph, Mo.		25. DATE RECD. BY LOCAL REG. <i>April 12, 1961</i>	26. REGISTRAR'S SIGNATURE <i>Mr. Clark Goodell</i>			

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION  
*C. Smith M.D.*

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 me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Eugene Wood

Licensed Embalmer No. 3804

P. O. Address 319 So 10th, Hg

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.