

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-024114

STATE FILE NUMBER

AMENDED

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 684

FILED JUL 17 1961

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in 1b 33yrs	c. CITY OR TOWN St. Joseph Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph Hospital		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 223No 8th Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Clarence Middle J Last DeVault	4. DATE OF DEATH Month June Day 30 Year 1961
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5. SEX: Male	6. COLOR OR RACE: White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH: Jan. 8, 1889	9. AGE (last birthday): 72	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Re. Flagman	10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (City and state or country) Forest City, Mo	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Commodore DeVault,	13b. MOTHER'S MAIDEN NAME Emma Jane Perry	14. NAME OF HUSBAND OR WIFE None
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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) no	16. SOCIAL SECURITY NO.	17. INFORMANT Address Mrs. Ralph Waker, St. Joseph, Mo
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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: IMMEDIATE CAUSE (a) Cerebral vascular accident with left hemiplegia 1 day		INTERVAL BETWEEN ONSET AND DEATH 5 yr.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Arteriosclerosis, Generalized	
	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 checked="" 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 6:29 a.m. Month, Day, Year 6/30/61	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
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21. I attended the deceased from 6-29-61 to 6/30/61 and last saw DECEASED him alive on 6-30-61 Death occurred at 5:15 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Donald E. Sklenar M.D. (Degree or title)	22b. ADDRESS Social Welfare Board, 10th & Olive Patee Hall, St. Joseph, Mo.	22c. DATE SIGNED 7-3-61
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 7/3/61	23c. NAME OF CEMETERY OR CREMATORY Forest City Cemetery Forest City, Mo	23d. LOCATION (City, town, or county) (State)
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24. FUNERAL DIRECTOR John Ruppert ADDRESS St. Joseph, Mo	25. DATE RECD. BY LOCAL REG. July 10, 1961	26. REGISTRAR'S SIGNATURE Mrs. Clara Goodell
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DATE AMENDED
INSTEAD OF
DOCUMENT
SHOULD READ
BY AFFIDAVIT OF

D.E. Sklenar, M.D. MEDICAL CERTIFICATION

JUL 17 1961

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 John E. Stupak

Licensed Embalmer No. 3986

P. O. Address St. Joseph

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.