

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-031981
STATE FILE NUMBER

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 971

AMENDED

FILED 007 2 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) St. Joseph			Length of stay in 1b 45yrs		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 St. Joseph Hospital				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 224 Blake		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Netta Middle Frances Last Noonan						4. DATE OF DEATH Month Sept. Day 23 Year 1961		
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Junell, 1887	9. AGE (last birthday) 74	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper			10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (City and state or country) Troy Kansas		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Anson Whetstine			13b. MOTHER'S MAIDEN NAME Sarah Frances Graves			14. NAME OF HUSBAND OR WIFE Patrick Noonan		
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 Address Patrick Noonan, 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 Unknown	
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) Cellulitis foot ; diabetes mellitus						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 type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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.) removed from 7/19/46		20f. CITY, TOWN, OR LOCATION St. Joseph, Mo		COUNTY STATE		
21. I attended the death personally 8/18/61 to 9/23/61 and last saw her alive on 9/18/61 . Death occurred at 12:20 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) Tracy Redmond MD				22b. ADDRESS St. Joseph, Mo		22c. DATE SIGNED 9/26/61		
23a. BURIAL CREATION, REMOVAL (Specify) Burial Removal		23b. DATE 9/25/61		23c. NAME OF CEMETERY OR CREMATORY St. James Cemetery		23d. LOCATION (City, town, or county) (State) Fanning, Kansas		
24. FUNERAL DIRECTOR Phyllis Rupp		ADDRESS St. Joseph, Mo		25. DATE RECD. BY LOCAL REG. Sept. 27, 1961		26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell		

DOCUMENT

BY AFFIDAVIT OF

L. W. Redmond, M.D., CERTIFICATION

DATE AMENDED
INSTEAD OF
SHOULD READ
ITEM NO.

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,

~~by~~ _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

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.