

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

042

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982

-61-031987
STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

FILED OCT 2 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 lb Life	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 DOA Methodist Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 602 No. 10th St. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First BONNIE Middle JUNE Last PINION	4. DATE OF DEATH Month September Day 26 Year 1961
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5. SEX Female	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 2/20/45	9. AGE (last birthday) 16	IF UNDER 1 YEAR Months _____ Days _____	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) Fountain Clerk	10b. KIND OF BUSINESS OR INDUSTRY Herman Drug Store	11. BIRTHPLACE (City and state or country) St. Joseph Missouri	12. CITIZEN OF WHAT COUNTRY U S A
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13a. FATHER'S NAME Fielden G. Pinion	13b. MOTHER'S MAIDEN NAME Laura P. Christian	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 Mr. Fielden G. Pinion Address 602 No. 10th St. 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) Traumatic shock + hemorrhage left scapula +		INTERVAL BETWEEN ONSET AND DEATH at once
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Broken neck + fractured clavicle		at once
DUE TO (c) Fall from skidding car		at once

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Was leaning against left rear door which opened		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 checked="" 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 1:30 Month, Day, Year Sept 26 61	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) highway	20f. CITY, TOWN, OR LOCATION Buchanan COUNTY MO STATE
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21. I attended the deceased from wounded body and last saw her alive on Sept 26 61 Death occurred at 1:30 PM on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE (Degree or title) St. E. Melaney M.D. Coronor	22b. ADDRESS 214 Westpatrick St. Joseph 8, Mo	22c. DATE SIGNED Sept 26 61
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9/30/61	23c. NAME OF CEMETERY OR CREMATORY Stewartville Cemetery	23d. LOCATION (City, town, or county) Stewartville Missouri
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24. FUNERAL DIRECTOR Stamer Funeral Home ADDRESS St. Joseph, Mo.	25. DATE RECD. BY LOCAL REG. Sept 29 1961	26. REGISTRAR'S SIGNATURE Mrs. Clark Handell
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 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 Ma

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.