

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-005652

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 224

FILED MAR 5 1962

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 4 months		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 State Hospital #2			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (if outside, give location) 1612 Savannah Ave.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First MARGARET Middle RIDDLE Last RIDDLE				4. DATE OF DEATH Month February Day 13 Year 1962									
5. SEX Female		6. COLOR OR RACE White		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>		8. DATE OF BIRTH 6-14-1882		9. AGE (last birthday) 79		IF UNDER 1 YEAR Months Days		IF UNDER 24 HR Hours Min.	
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) Clinton Co., Mo.		12. CITIZEN OF WHAT COUNTRY U. S. A.					
13a. FATHER'S NAME Thomas Gaunt				13b. MOTHER'S MAIDEN NAME Unknown				14. NAME OF HUSBAND OR WIFE None					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Nina Queen, St. Joseph, Missouri Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchiectasis										INTERVAL BETWEEN ONSET AND DEATH 5 years			
DUE TO (b) Generalized arteriosclerosis										10 years			
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			
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 7:20 A Month, Day, Year 2-13-62		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 St. Joseph, Mo.		COUNTY Buchanan		STATE Missouri			
21. I attended the deceased from 2-13-62 to 2-13-62 and last saw her <input checked="" type="checkbox"/> alive on 2-13-62 Death occurred at 7:20 A m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <i>Mohammed Taha M.D.</i> (Degree or title)						22b. ADDRESS St. Joseph State Hospital			22c. DATE SIGNED 2-21-62				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2-14-62		23c. NAME OF CEMETERY OR CREMATORY Odd Fellows Public Cemetery			23d. LOCATION (City, town, or county) St. Joseph, Missouri			(State) Mo.			
24. FUNERAL DIRECTOR <i>John E. Sapp</i> ADDRESS St. Joseph, Mo.				25. DATE RECD. BY LOCAL REG. Feb. 23, 1962		26. REGISTRAR'S SIGNATURE <i>Mrs. Clark Randall</i>							

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

NO A M M A D T A H A M D MEDICAL CERTIFICATION

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, 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.