

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

62-009952
STATE FILE NUMBER

DO NOT WRITE ON THIS STUD

AMENDED

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 327

FILED MAR 26 1962

VS 300
Rev. 4/59

1 5117

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DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DOCUMENT

M. TAHIR, M.D. MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>Buchanan</u>		a. STATE <u>Missouri</u>		b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph, Missouri</u>		Length of stay in 1b <u>11 Months</u>		c. CITY OR TOWN <u>Kansas City, Missouri</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital #2</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>3537 Main Street</u>	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		5. Year
First <u>Melvin</u> Middle <u>R.</u> Last <u>Gustafson</u>			Month <u>March</u> Day <u>16</u>		Year <u>1962</u>
5. SEX	6. COLOR OR RACE	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (last birthday)	IF UNDER 1 YEAR IF UNDER 24 HR
<u>Male</u>	<u>White</u>		<u>Nov. 9, 1936</u>	<u>25</u>	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country)	
<u>None</u>		<u>None</u>		<u>Nebraska U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY		13a. FATHER'S NAME			
<u>U.S.A.</u>		<u>Ralph E. Gustafson</u>			
		13b. MOTHER'S MAIDEN NAME		14. NAME OF HUSBAND OR WIFE	
		<u>Bernice L. Cozad</u>		<u>None</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address	
<u>No</u>		<u>None</u>		<u>State Hospital #2 Records</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Secondary Anemia</u>					<u>Unknown</u>
DUE TO (b) <u>Chronic Cystitis and Urinary Obstruction</u>					<u>Unknown</u>
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 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.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from <u>March 12, 1962</u> to <u>March 16, 1962</u> and last saw him alive on <u>March 16, 1962</u>		Death occurred at <u>1:10 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Mohammed Tahir M.D.</u>		22b. ADDRESS <u>State Hospital #2, St. Joseph, Mo.</u>		22c. DATE SIGNED <u>3/16/62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>March 17, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Wyuka Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Lincoln, Nebraska</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Meierhoffer-Fleeman Inc., St. Joseph, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Mar. 24, 1962</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. Clark Goodell</u>	

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 Raymond H. Snow

Licensed Embalmer No. 5147

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.