

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-030116

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 983

STATE FILE NUMBER

FILED SEP 10 1962

VS 300 Rev. 4/59

5117
25117

3
4 0
5 2
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7 0
8 2

94200

10

11

12 90-0

13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF *D.E. Sklenar M.D.*

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 20yrs	c. CITY OR TOWN St. Joseph
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 6821 Marie St		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 6821 Marie
3. NAME OF DECEASED (Type or print) First Middle Last James Albert Ray			4. DATE OF DEATH Month Day Year Aug. 28, 1962
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH May 2, 1878
9. AGE (last birthday) 84		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (City and state or country) Rae Co, Mo
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME John Ray	
13b. MOTHER'S MAIDEN NAME Unk		14. NAME OF HUSBAND OR WIFE none	
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 John Kates, 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) <u>Arteriosclerotic Heart Disease</u>			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)			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 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>8/17/62</u> to <u>8/28/62</u> and last saw him alive on <u>8/17/62</u> Death occurred at <u>1:30 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>D.E. Sklenar M.D.</i> (Degree or title)		22b. ADDRESS SOCIAL WELFARE BOARD 10th & Olive, St. Joseph, Mo.	22c. DATE SIGNED 8/29/62
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8/30/62	23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery	23d. LOCATION (City, town, or county) (State) St. Joseph, Mo
24. FUNERAL DIRECTOR <i>John E. Kepp</i>	ADDRESS St. Joseph, Mo	25. DATE RECD. BY LOCAL REG. Aug 31, 1962	26. REGISTRAR'S SIGNATURE <i>Wm Clark Handell</i>

USE BLACK INK OR TYPEWRITER RIBBON

Permitted 8/29/62

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,

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

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

John E. Rupp

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.