

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-033781

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 1149

FILED OCT 15 1962

VS 300
Rev. 4/59

15117
25117

3
4 1
5 1
6
7 0
8 1
9 150X
10
11
12 3-0
13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF: J.R.M. Daniel, M.D. MEDICAL CERTIFICATION

USE BLACK INK OR TYPEWRITER RIBBON

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 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 St. Joseph's Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1820 Olive St. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MARGARET Middle REGINA Last FARRELL			4. DATE OF DEATH Month October Day 9 Year 1962
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 8-11-1917
9. AGE (last birthday) 45		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) Beauty Operator		10b. KIND OF BUSINESS OR INDUSTRY Beauty Shop	11. BIRTHPLACE (City and state or country) St. Joseph, Mo.
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME Stanley Brush	
13b. MOTHER'S MAIDEN NAME Theresa Swinchocki		14. NAME OF HUSBAND OR WIFE Merlin Farrell	
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 Merlin Farrell Address 1820 Olive City
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Recurrent carcinoma of the esophagus, with laryngeal and esophageal obstruction. 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 type="checkbox"/> No <input type="checkbox"/> Unknown			INTERVAL BETWEEN ONSET AND DEATH 6 months.
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 October 26, 1961 to October 9, 1962 and last saw him alive on October 9, 1962 . Death occurred at 7:55 P m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>J.R.M. Daniel, M.D.</i> (Degree or title)		22b. ADDRESS 902 Edmond Street	22c. DATE SIGNED 10/11/62
23a. BURIAL, CREMATION, REMOVAL Burial	23b. DATE 10-12-1962	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION (City, town, or county) (State) St. Joseph, Mo.
24. FUNERAL DIRECTOR H. O. Sidenfaden & Son ADDRESS St. Joseph, Mo.		25. DATE RECD. BY LOCAL REG. Oct. 11, 1962	26. REGISTRAR'S SIGNATURE <i>Mrs. Clark Goodell</i>

Permitted 10/11/62

Dr. M. Daniel

x St. Joseph's Hospital St. Joseph, Mo.
 x 1320 Olive St. St. Joseph, Mo.
 1962 October 2nd
 Foreign White
 Boston Operator Security Shop
 Stanley Bush Thomas Swinchocki
 No. 1320 Olive St. St. Joseph, Mo.

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 Robert G. Gage
x

Licensed Embalmer No. 3308

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.

St. Joseph, Mo. 1320 Olive St.