

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE **042**

1000

857

63-027371

STATE FILE NUMBER

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

DO NOT WRITE ON THIS STUB

AMENDED

FILED JUL 22 1963

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,		c. CITY OR TOWN St. Joseph,	
Length of stay in 1b Life		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 706 South 13th Street		d. STREET ADDRESS (If outside, give location) 706 South 13th Street	
3. NAME OF DECEASED (Type or print) First MARIE Middle HILLYARD Last SPRATT		4. DATE OF DEATH Month July Day 11 Year 1963	
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 June 24, 1895
9. AGE (last birthday) 68		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) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (City and state or country) St. Joseph, Missouri
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME Newton S. Hillyard	
13b. MOTHER'S MAIDEN NAME Nona Marie Coie		14. NAME OF HUSBAND OR WIFE Elliott C. Spratt	
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. Elliott C. Spratt		Address 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) Probable coronary occlusion			INTERVAL BETWEEN ONSET AND DEATH Immediate
DUE TO (b) Generalized arteriosclerosis gravis			1-2 yrs.
DUE TO (c) _____			_____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a), (b), or (c). in 1959-1960. 5 yrs of abd. and. vert. (arteriosclerosis, hypomagnesemia, osteoarthritis open, adenoiditis, influenza, otitis media)			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 10-10-46 to 6-26-63 and last saw her alive on 6-26-63 Death occurred at 3:00 PM m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Thompson P. Potter, M.D.		22b. ADDRESS 731 Faxon St. St. Joseph, 54, Mo.	
22c. DATE SIGNED 7-13-63		22d. LOCATION (City, town, or county) (State) St. Joseph Missouri	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE July 13, 1963	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	
23d. LOCATION (City, town, or county) (State) St. Joseph Missouri		24. FUNERAL DIRECTOR ADDRESS Meierhoffer-Fleeman Inc., St. Joseph, Mo.	
25. DATE RECD. BY LOCAL REG. July 17, 1963		26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell	

VS 300
Rev. 4/59

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DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DOCUMENT

BY AFFIDAVIT OF **T.P. Potter, M.D.**

USE BLACK INK OR TYPEWRITER RIBBON

JUL 23 1963

Permit issued 7-12-63

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.

0-49

Student _____
Signature of Student Embalmer

Signed [Signature]

Licensed Embalmer No. 4679

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.