

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-031445

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 987

STATE FILE NUMBER

FILED AUG 21 1963

| | | | | | |
|---------------------------|--|--|--|--|--|
| DO NOT WRITE ON THIS STUB | AMENDED | | | | |
| VS 300 Rev. 4/59 | DATE AMENDED | | | | |
| 15117 | INSTEAD OF | | | | |
| 25117 | AMENDMENTS ON THIS RECORD ARE AS FOLLOWS | | | | |
| 3 | DOCUMENT | | | | |
| 4 / | BY AFFIDAVIT OF | | | | |
| 5 2 | C.C. DuMont-Medical | | | | |
| 6 | SHOULD READ | | | | |
| 7 / | ITEM NO. | | | | |
| 8 2 | CERTIFICATION | | | | |
| 94500 | USE BLACK INK OR TYPEWRITER RIBBON | | | | |
| 10 | | | | | |
| 11 | | | | | |
| 12 90-0 | | | | | |
| 13 10 | | | | | |

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|--|---|--|---|
| 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 65 years | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3340 Seneca | | d. STREET ADDRESS (If outside, give location) 3340 Seneca | |
| 3. NAME OF DECEASED (Type or print) First LULA Middle MAY Last TOWNSEND | | 4. DATE OF DEATH Month August Day 9 Year 1963 | |
| 5. SEX female | 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 8/24/1868 |
| 9. AGE (last birthday) 94 | | 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) Pittsburgh, Kansas |
| 12. CITIZEN OF WHAT COUNTRY USA | | 13a. FATHER'S NAME John Ferguson | |
| 13b. MOTHER'S MAIDEN NAME unknown | | 14. NAME OF HUSBAND OR WIFE Lewis J. | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | 17. INFORMANT Address Mo. Edwin R. Townsend, R.R. #3, St. Joseph | |
| 16. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerosis | | INTERVAL BETWEEN ONSET AND DEATH 6 mo | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | 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 | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | |
| 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 8-9-63 to 8-9-63 and last saw her ^{her} _{him} alive on 8 9 63 Death occurred at 9:10 p. m on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) Edwin R. Townsend | | 22b. ADDRESS St. Joseph Mo | |
| 22c. DATE SIGNED 8-13-63 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) burial | 23b. DATE 8/12/1963 | 23c. NAME OF CEMETERY OR CREMATORY Memorial Park | |
| 23d. LOCATION (City, town, or county) St. Joseph Missouri | | | |
| 24. FUNERAL DIRECTOR Hester-Bowman | | 25. DATE RECD. BY LOCAL REG. Aug 19, 1963 | |
| ADDRESS St. Joseph, Mo. | | 26. REGISTRAR'S SIGNATURE Mrs. Clark Gardell | |

103-034-170

Permit issued 8-12-63

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.

Student _____

Signature of Student Embalmer

Signed Eugene Wood

Licensed Embalmer No. 3804

P. O. Address 319 So 10th St, J. J. Griffith, N.C.

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.