

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**63-047092**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 1508

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

**FILED JAN 8 1964**

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>Buchanan</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph,</b>		c. CITY OR TOWN <b>St. Joseph,</b>	
Length of stay in 1b <b>12hrs</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Joseph Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>704 No 12th</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Anthony</b> Last <b>Jimenez</b>			4. DATE OF DEATH Month <b>Dec</b> Day <b>30</b> Year <b>1963</b>		
--	--	--	---	--	--

5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec 29, 1963</b>	9. AGE (last birthday) <b>—</b>	IF UNDER 1 YEAR Months <b>—</b> Days <b>—</b>	IF UNDER 24 HR Hours <b>12</b> Min. <b>25</b>
--------------------	-------------------------------	--	--------------------------------------	---------------------------------	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	11. BIRTHPLACE (City and state or country) <b>St. Joseph, Mo</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
--	--	---	--

13a. FATHER'S NAME <b>Jose G Jimenez</b>	13b. MOTHER'S MAIDEN NAME <b>Dorothy Marsh</b>	14. NAME OF HUSBAND OR WIFE <b>none</b>
---	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT Address <b>Jose G Jimenez St. Joseph, Mo</b>
---	--	---

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) <b>Immaturity - 5-5 1/2 mo. Gestation</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Premature Labor</b>	
DUE TO (c) <b>Premature separation of Placenta.</b>		
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 <b>—</b> a.m. <b>—</b> p.m. <b>—</b>	Month, Day, Year <b>—</b>
--	---------------------------

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 **12-29-63** to **12/30/63** and last saw him live on **12-30-63**.  
Death occurred at **9:40 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>E. E. Wadlow M.D.</b>	22b. ADDRESS <b>620 Francis St. Joseph, Mo.</b>	22c. DATE SIGNED <b>1-2-64.</b>
--	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>12/31/63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt Olivet Cemetery</b>	23d. LOCATION (city, town, or county) (State) <b>St. Joseph, Mo</b>
--	---------------------------	---	--

24. FUNERAL DIRECTOR <b>John Rupp</b>	ADDRESS <b>St. Joseph, Mo</b>	25. DATE RECD. BY LOCAL REG. <b>Jan. 6, 1964</b>	26. REGISTRAR'S SIGNATURE <b>Mrs. Clark Goodell</b>
--	----------------------------------	---	--

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF **E. E. Wadlow, M.D.**

VS 300 Rev. 4/59	DATE AMENDED
<b>15117</b>	
<b>25117</b>	
<b>3</b>	
<b>4 0</b>	
<b>5 0</b>	
<b>6</b>	
<b>7 0</b>	
<b>8 2</b>	
<b>9 7615</b>	
<b>10</b>	
<b>11</b>	
<b>12 3-0</b>	
<b>13 1-0</b>	

Permit renewed 12-31-63

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,

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.