

FILED OCT 16 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **29476**

BIRTH NO. 47329-50 REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 1117

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, write RURAL and give township) OR TOWN St Joseph		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Joseph <u>0117</u>	
c. LENGTH OF STAY (in this place) 3 Weeks		d. STREET ADDRESS (If rural, give location) 1915 No. 29th St.	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1915 No. 29th St.			

3. NAME OF DECEASED (Type or Print)	a. (First) Robert	b. (Middle) Kipp	c. (Last) Kieber	4. DATE OF DEATH (Month) (Day) (Year) Oct. 1, 1950
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED Never Married	8. DATE OF BIRTH Aug. 2, 1950	9. AGE (In years last birthday) 1 YEAR 29 MONTHS 1 DAY 29 HOURS 1 MIN.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St Joseph, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Dr. Robert Wm Kieber	13b. MOTHER'S MAIDEN NAME Madeline I Tobin	14. NAME OF HUSBAND OR WIFE None
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Dr Robert Wm. Kieber ADDRESS St Joseph, Mo.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure; asthenia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Thyropathy - enlargement	(b) Upper respiratory infection	1 wk
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.	DUE TO (c) Thyroid and heart enlarged by post mortem X-ray		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	-		273X

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from _____, 19____, to Oct 1, 1950, that I last saw the deceased alive on Oct 1, 1950, and that death occurred at 6 A m., from the causes and on the date stated above.

23a. SIGNATURE Grant M.D. (Degree or title)	23b. ADDRESS St. Joseph, Mo.	23c. DATE SIGNED 10-1-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 10-2-50	24c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	24d. LOCATION (City, town, or county) (State) St Joseph, Mo.
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DATE REC'D BY LOCAL REG. Oct 6, 1950	REGISTRAR'S SIGNATURE Carl C. ...	25. FUNERAL DIRECTOR'S SIGNATURE Norman ... ADDRESS 1802 Union St
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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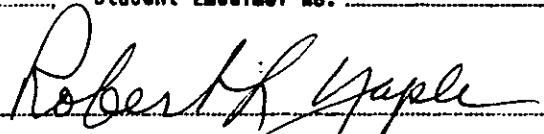
STATEMENT BY LICENSED EMBALMER

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.

Signed.....



Signed.....

Student Embalmer

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 this body is not embalmed, fact should be so stated above.