

STANDARD CERTIFICATE OF DEATH

State File No.

No. 300
10-48

LED JUN 8 1953

REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 617

1. PLACE OF DEATH a. COUNTY Buchanan 0111		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	
c. LENGTH OF STAY (in this place) 50 yrs.		d. STREET ADDRESS (If rural, give location) 6534 Brown St.	
d. FULL NAME OF HOSPITAL OR INSTITUTION 6534 Brown St. (Home)			

3. NAME OF DECEASED (Type or Print) RILEY			4. DATE OF DEATH (Month) (Day) (Year) 5 21 1953		
a. (First)	b. (Middle) HELM		c. (Last)		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married	8. DATE OF BIRTH 12-25-1885	9. AGE (In years last birthday) 67	IF UNDER 12 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) No		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (City and State or Foreign Country) Waterloo, Iowa /	
12. CITIZEN OF WHAT COUNTRY? USA					

13a. FATHER'S NAME Deloris Helm		13b. MOTHER'S MAIDEN NAME Rosie Barnes		14. NAME OF HUSBAND OR WIFE None	
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. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS James Helm, 6534 Brown St.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis			INTERVAL BETWEEN ONSET AND DEATH 5
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic Rheumatism			?
		DUE TO (c)			
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION None		19b. MAJOR FINDINGS OF OPERATION 4222		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from May 21 1953, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 3:00A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) B. H. Tadlock M.D. nat. Council		23b. ADDRESS St. Joseph, 703 So. 13 th St.		23c. DATE SIGNED May 26 1953	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 5-23-1953		24c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery	
				24d. LOCATION (City, town, or county) Halls, Missouri (State)	

DATE REC'D BY LOCAL REG. June 1, 1953		REGISTRAR'S SIGNATURE Bethel M. Allison 485-g		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Joseph Ruppert, Joseph, Mo.	
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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
Student Embalmer

Signed

John E. Rupp
Licensed Embalmer No. *3956*

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.