

FILED NOV 13 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33191

State File No.

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 1177

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>		c. CITY OR TOWN <u>St. Joseph</u>	
c. LENGTH OF STAY (In this place) <u>70 Yrs</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Joseph's Hospital</u>		e. STREET ADDRESS (If rural, give location) <u>907 North 20th St.</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Mary</u>	b. (Middle) <u>B.</u>	c. (Last) <u>Kill</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 31, 1956</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>June 23, 1878</u>	9. AGE (In years last birthday) <u>78</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Kansas</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>August Weiche</u>	13b. MOTHER'S MAIDEN NAME <u>Caroline Leber</u>	14. NAME OF HUSBAND OR WIFE <u>John Kill</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs A.F. Barmann</u>	ADDRESS <u>St. Joseph, Mo.</u>
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>4 mo.</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Rheumatic heart disease - failure</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ 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 _____	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) <u>416x</u>
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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 10-23, 1956 to 10-31, 1956, that I last saw the deceased live on 10-31, 1956 and that death occurred at 3:50 p m., from the causes and on the date stated above.

23a. SIGNATURE <u>J. F. W. [Signature]</u> (Degree or title) _____	23b. ADDRESS <u>2603 Fredericks Avenue</u> City _____	23c. DATE SIGNED <u>11-1-56</u>
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24. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>11-3-56</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>St. Joseph, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>Nov 7, 1956</u>	REGISTRAR'S SIGNATURE <u>Evelyn M. Allison</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Norman W. Sidenfaden</u>	ADDRESS <u>St. Joseph, Mo</u>
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WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

48 5

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.....
Robert H. Gaylor

Licensed Embalmer No. 3308

P. O. Address St. Joseph, M

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.