

Health,
Public
Service

FILED AUG 5 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

23572
STATE FILE NUMBER

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 845

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-54

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>		c. CITY OR TOWN <u>St. Joseph</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR <u>Geforth Nursing Home</u> INSTITUTION <u>1804 Parson St.</u>		d. STREET ADDRESS <u>1601 Buchanan Ave</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
Length of stay in lb <u>65 yrs.</u>			
3. NAME OF DECEASED (Type or print) First <u>Coventry</u> Middle <u>Archibald</u> Last <u>Archibald</u>		4. DATE OF DEATH Month <u>July</u> Day <u>29</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 7, 1872</u>
9. AGE (In years last birthday) <u>85</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Sash Maker</u>	11. BIRTHPLACE (City and state or country) <u>Belleville, Illinois</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>Russell, Archibald</u>	13b. MOTHER'S MAIDEN NAME <u>Ellen McIndoo</u>	14. NAME OF HUSBAND OR WIFE <u>Matilda M. Archibald</u>	
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>487-01-3109</u>	17. INFORMANT <u>G. B. Archibald</u> Address <u>St. Joseph, Missouri</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Old myocardial insufficiency</u> DUE TO (c) <u>Arteriosclerosis Sen.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Terminal Pneumonia</u>			INTERVAL BETWEEN ONSET OF DEATH <u>48 hours</u> <u>Yes</u>
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.) <u>Recent Fract. Hip - Open Reduction</u>	
20c. TIME OF INJURY Hour <u>10:55</u> Month, Day, Year <u>7-29-57</u> a.m. p.m.			
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.) <u>10-55</u>	20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>St. Joseph, Missouri</u>	
21. I attended the deceased from <u>10:00 A.M. 7-29-57</u> to <u>7-29-57</u> and last saw him alive on <u>7-29-57</u> Death occurred at <u>10:00 A.M. 7-29-57</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Robert W. Keebe, MD</u> (Degree or title)		22b. ADDRESS <u>St. Joseph, Mo</u>	22c. DATE SIGNED <u>7-30-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>August 1, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Joseph, Missouri</u>
24. FUNERAL DIRECTOR <u>Meierhoffer-Fleeman, Inc., St. Joseph, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>Aug. 2, 1957</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Robert Fulton</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

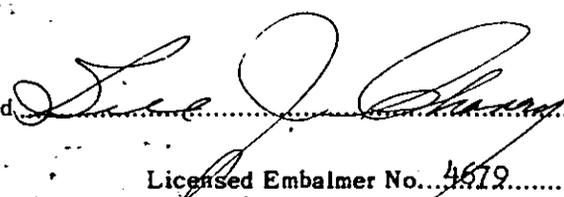
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AUG 4 1958

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 

Licensed Embalmer No. 4679

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.