

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-013319
STATE FILE NUMBER

FILED APR 21 1958

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 405

300
-57
2

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Macon	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Macon	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hospital#2	Length of stay in lb 26 years	d. STREET ADDRESS (If outside, give location)	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First OMA Middle LEE Last KEISTER			4. DATE OF DEATH Month April Day 14 Year 1958	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 19, 1894	
9. AGE (In years last birthday) 63		IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (City and state or country) Missouri	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME William Lee Jones		
13b. MOTHER'S MAIDEN NAME Iola Mae Poore		14. NAME OF HUSBAND OR WIFE Carl, Keister		

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 Address Records, State Hospital#2, St. Joseph Mo.
--	--	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mesentrie Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 24 hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Hypertensive Heart Disease	5 years
	DUE TO (c) Recovering from recent hip fracture	3 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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 5:00 a.m. a Month April Day 14 Year 1958	20d. INJURY OCCURRED WHILE AT <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 Dec. 1957 to April 14, 1958 last saw her alive on April 14, 1958 Death occurred at 5:00 a m on the date stated above; and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <i>Muhammad Tahir M.D.</i>	22b. ADDRESS State Hospital#2, St. Joseph Mo.
22c. DATE SIGNED 4/14/58	

23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE April 14, 1958	23c. NAME OF CEMETERY OR CREMATORY Bevier, Missouri	23d. LOCATION (City, town, or county) (State)
---	------------------------------------	---	---

24. FUNERAL DIRECTOR ADDRESS Heston-Bowman St. Joseph, Mo.	25. DATE RECD. BY LOCAL REG. April 14 1958	26. REGISTRAR'S SIGNATURE <i>Mrs. Clark Carroll</i>
--	--	--

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

APR 22 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 *William Spalding*

Licensed Embalmer No. *4535*

P. O. Address *3195 10th Ave*

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.