

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-020937

STATE FILE NUMBER

693

FILED JUL 7 1958 Registration District No. 42 Primary Registration District No. 1000 Registrar's No.

300
1-57

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, give TOWNSHIP only) OR TOWN St. Joseph		c. CITY OR TOWN St. Joseph 0117	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 732 South 16th		d. STREET ADDRESS (If outside, give location) 732 South 16th	
3. NAME OF DECEASED (Type or print) First Middle Last KATHERINE BAUMAN		4. DATE OF DEATH Month Day Year June 28, 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 29, 1873
9. AGE (In years at birthday) 85		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (City and state or country) New Offenburg, Mo.
12. CITIZEN OF WHAT COUNTRY? USA		13. MOTHER'S MAIDEN NAME Agnes Ritter	
13a. FATHER'S NAME John Grieshaber		14. NAME OF HUSBAND OR WIFE Henry Bauman	
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 Otilia Bauman		Address 732 So. 16th City	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Insufficiency DUE TO (b) Atherosclerosis DUE TO (c) Atherosclerotic Heart Disease			INTERVAL BETWEEN ONSET AND DEATH 6/16/58 1 yr 71
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4200			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 Month, Day, Year 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.)	
20f. CITY, TOWN, OR LOCATION COUNTY STATE			
21. I attended the deceased from 6-16-58 to 6-29-58 and last saw her alive on 6-28-58 Death occurred at 5:35 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Clifton Smith M.D.		22b. ADDRESS 218 N 7th St Joseph Mo	
22c. DATE SIGNED 6/30/58			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE July 1, 1958	
23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town, or county) (State) St. Joseph, Mo.	
24. FUNERAL DIRECTOR Norman W. Silenfeld		25. DATE RECD. BY LOCAL REG. June 30, 1958	
26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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Dr. Clifton Smith

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 D. Gaylor*
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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.