

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-031835
STATE FILE NUMBER

8
FILED OCT 14 1958 Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1071

S. 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		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Joseph, ⁰¹¹⁷		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph Hosp		Length of stay in lb 60yrs	d. STREET ADDRESS 809 No 23rd		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Catherine M Mansbarger			4. DATE OF DEATH Month Day Year Oct. 3, 1958		
5. SEX Female ^c	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 14, 1894	9. AGE (In years last birthday) 64	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House keeper		10b. KIND OF BUSINESS OR INDUSTRY Self Home	11. BIRTHPLACE (City and state or country) Maryville Mo		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME William T McDonnell		13b. MOTHER'S MAIDEN NAME Mary Ellen		14. NAME OF HUSBAND OR WIFE deceased	
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 John T Mansbarger, 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) Embolus Fat					INTERVAL BETWEEN ONSET AND DEATH 48 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Fracture comminuted Rt hip					2 days
DUE TO (c)					
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 Month, Day, Year a.m. p.m.					
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 <u>Oct 58</u> to <u>Oct. 3, 1958</u> and last saw her alive on <u>3 Oct 1958</u> Death occurred at <u>12:20 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>Dr. John L. Mothershead</i>			22b. ADDRESS <i>2603 Fredrick</i>		22c. DATE SIGNED <i>10-6-58</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/6/58	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town, or county) (State) St. Joseph, Mo
24. FUNERAL DIRECTOR Rupp Funeral Home, St. Joseph, Mo		ADDRESS	25. DATE RECD. BY LOCAL REG. <i>Oct 8, 1958</i>		26. REGISTRAR'S SIGNATURE <i>Mrs. Clark Goodell</i>

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.

Dr. John L. Mothershead
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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, ~~_____~~, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *John E. Rupp*

Licensed Embalmer No. *3986*

P. O. Address *St. Joseph*

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.