

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-043304

STATE FILE NUMBER
1376

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 1376

FILED JAN 5 1959

300 4
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 checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Joseph
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Arnold Nursing Home		Length of stay in 1b life	d. STREET ADDRESS (If outside, give location) 1024 Charles

3. NAME OF DECEASED (Type or print) First Middle Last AUGUST F. HASPEL			4. DATE OF DEATH Month Day Year Dec. 17, 1958		
---	--	--	--	--	--

5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 28, 1872	9. AGE (In years last birthday) 86	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
-----------------------	----------------------------------	---	--	--	--------------------------------	--------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Bookkeeper	10b. KIND OF BUSINESS OR INDUSTRY Railroad Co.	11. BIRTHPLACE (City and state or country) St. Joseph, Mo.	12. CITIZEN OF WHAT COUNTRY? USA
---	--	--	--

13a. FATHER'S NAME W. F. Haspel	13b. MOTHER'S MAIDEN NAME Rose Ross	14. NAME OF HUSBAND OR WIFE
---	---	-----------------------------

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. 702-12-9918	17. INFORMANT Address Mrs. Bertha Long, 1024 Charles, 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) Pneumonia, Terminal		INTERVAL BETWEEN ONSET AND DEATH 6 wks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Fracture 12 D Vertebra	
	DUE TO (c) 9040	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 21		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2

20a. ACCIDENT <input checked="" 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.) Fell at home
--	---

20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. Nov. 5, 1958

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) at home	20f. CITY, TOWN, OR LOCATION St. Joseph Buchanan Mo.	COUNTY Buchanan	STATE Mo.
---	--	--	---------------------------	---------------------

21. I attended the deceased from 5 Nov 58 to 17 Dec 58 and last saw him alive on 17 Dec 58 Death occurred at 12:15p. m on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE (Degree or title) J. J. Motherhead M.D.	22b. ADDRESS 2603 Fredrich	22c. DATE SIGNED 12-22-58
--	--------------------------------------	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 12/19/1958	23c. NAME OF CEMETERY OR CREMATORY Ashland Cemetery	23d. LOCATION (City, town, or county) (State) St. Joseph Missouri
--	--------------------------------	---	---

24. FUNERAL DIRECTOR ADDRESS Heaton Burson St. Joseph, Mo.	25. DATE RECD. BY LOCAL REG. Dec. 26, 1958	26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell
--	--	--

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
 MEDICAL CERTIFICATION
 Dr. J. J. Motherhead

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 *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.