Health, Welfare Public Service

300 1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-004536
STATE FILE NUMBER

FILED FEB 24 1959

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 176

1. PLACE OF DEATH
a. COUNTY: Buchanan
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): St. Joseph — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): State Hospital #2 — Length of stay in 1b: 33 yrs.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Caldwell
c. CITY OR TOWN: Breckenridge 0130 c — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): none — Reside on Farm: Yes [ ] No [ ]

3. NAME OF DECEASED (Type or print): First: Joe Middle: Last: Birks

4. DATE OF DEATH: Month: Feb. Day: 16, Year: 1959

5. SEX: male c

6. COLOR OR RACE: white

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: unknown c

9. AGE (In years last birthday): 72 — 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): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (City and state or country): Russia 6

12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: unknown

13b. MOTHER'S MAIDEN NAME: unknown

14. NAME OF HUSBAND OR WIFE: none

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.: unknown

17. INFORMANT Address: State Hosp. #2 Records

MEDICAL CERTIFICATION

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 Occlusion
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b):
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 4281

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X] 2

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

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

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

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 Feb. 16, 1959, to Feb. 16, 1959 and last saw him alive on Feb. 16, 1959
Death occurred at 5:00 P.m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): R P Price MD c

22b. ADDRESS: St. Joseph, Missouri

22c. DATE SIGNED: Feb. 17, 1959

23a. BURIAL, CREMATION, REMOVAL (Specify): removal

23b. DATE: Feb. 17, 1959

23c. NAME OF CEMETERY OR CREMATORY: Kirksville College/Osteopathy

23d. LOCATION (City, town, or county) (State): Kirksville, Missouri

24. FUNERAL DIRECTOR: Meerkoffer-Freeman Inc. by [illegible] — ADDRESS: St. Joseph, Mo.

25. DATE RECD. BY LOCAL REG.: Feb. 17, 1959

26. REGISTRAR'S SIGNATURE: Mrs Clark Gardell

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

Dr. R.P. Price

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.