

**DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-016823**

**FILED JUN 15 1959** 042

Registration District No. \_\_\_\_\_ Primary Registration District No. 1000 Registrar's No. 612

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>		Length of stay in 1b <u>90 Years</u>		c. CITY OR TOWN <u>St. Joseph</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Arnold Nursing Home</u> <u>701 S. 11th</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>1002 S. 14th</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Frances</u> Middle _____ Last <u>Logaburn</u>				4. DATE OF DEATH Month <u>June</u> Day <u>9</u> Year <u>1959</u>									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 12, 1866</u>		9. AGE (last birthday) <u>92</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (City and state or country) <u>Weston Missouri</u>			12. CITIZEN OF WHAT COUNTRY <u>USA</u>					
13a. FATHER'S NAME <u>George Brahler</u>				13b. MOTHER'S MAIDEN NAME <u>Christina Meyer</u>				14. NAME OF HUSBAND OR WIFE <u>Nicholas Logaburn</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. _____		17. INFORMANT Address <u>George Logaburn, St. Joseph, Mo.</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u>										INTERVAL BETWEEN ONSET AND DEATH <u>6-7m.</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis Gen.</u>										<u>Yrs</u>			
DUE TO (c) <u>Previous C.V.A.</u>										<u>Yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Ununited Fract. Rt Hip.</u>								PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		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.) <u>Fell out of bed</u>									
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.		Month, Day, Year <u>Several Months ago. Exact date not on record</u>											
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.) <u>at home</u>			20f. CITY, TOWN, OR LOCATION <u>St. Joseph,</u>		COUNTY <u>Buchanan, Mo.</u>		STATE				
21. I attended the deceased from <u>5-24-59</u> to <u>6-9-59</u> and last saw her alive on <u>6-9-59</u> Death occurred at <u>11:55 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <u>Robert W. Keller, M.D.</u>						22b. ADDRESS <u>St. Joseph, Mo</u>			22c. DATE SIGNED <u>6-10-59</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>June 12, 1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet, Cemetery</u>			23d. LOCATION (City, town, or county) (State) <u>St. Joseph, Missouri</u>						
24. FUNERAL DIRECTOR <u>H.O. Sickenfaden &amp; Son</u> <u>27. W. W. Co.</u>						ADDRESS <u>St. Joseph, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>June 11, 1959</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. Clark Goodell</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

(Licensed Embalmer's Statement on Reverse Side)

*Heber*

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*W. William Davenport*

Licensed Embalmer No. 4195

P. O. Address St. Joseph

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.