

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-016829

FILED JUN 15 1959

1000

609

STATE FILE NUMBER

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

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		Length of stay in 1b 45 years		c. CITY OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hospital #2			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1015 Isadore St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First ROBERT Middle LINDSAY Last McKEAN				4. DATE OF DEATH Month June Day 9, Year 1959					
5. SEX Male		6. COLOR OR RACE White		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH Feb. 15, 1877, 32		9. AGE (last birthday) IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoe Salesman			10b. KIND OF BUSINESS OR INDUSTRY Shoe Store		11. BIRTHPLACE (City and state or country) Mercer Co. Penn.		12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME James S. McKean			13b. MOTHER'S MAIDEN NAME Nancy Linsey			14. NAME OF HUSBAND OR WIFE Jessie McKean			
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. 491-09-0260		17. INFORMANT Address Records, State Hosp. #2, 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) General Debility with Extreme Malnutrition and Dehydration, Duration unknown DUE TO (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH Unknown		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)							PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
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 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 5-20-59 to 6-9-59 and last saw her/him alive on 6-9-59 Death occurred at 11:00 AM on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) Mohammad John M.D.				22b. ADDRESS State Hosp. #2, St. Joseph, Mo.		22c. DATE SIGNED 6-9-59			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE June 11, 1959		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet, Cemetery		23d. LOCATION (City, town, or county) (State) St. Joseph, Mo.			
24. FUNERAL DIRECTOR ADDRESS H.O. Sidenfaden & Son St. Joseph, Mo. June 11, 1959 N.W. Ke				25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed W. William Hlav

Licensed Embalmer No. 419

P. O. Address St. Joseph

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