

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

**59-020449**

FILED JUN 22 1959 042

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617

STATE FILE NUMBER

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|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Buchanan</b>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b> |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>                   |  | Length of stay in 1b<br><b>3 yrs</b>  | c. CITY OR TOWN <b>St. Joseph</b><br>Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>1611 Prospect Ave.</b> |  | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   | d. STREET ADDRESS (If outside, give location) <b>1611 Prospect Ave.</b><br>Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|--|--|--|---|--|--|--|
| 3. NAME OF DECEASED (Type or print)<br>First <b>NATHANIEL</b> Middle <b>CARR</b> Last <b>FLEMING</b> |  |  | 4. DATE OF DEATH<br>Month <b>June</b> Day <b>8</b> Year <b>1959</b> |  |  |  |
|--|--|--|---|--|--|--|

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|-----------------------|----------------------------------|---|--|--|--|--|
| 5. SEX<br><b>Male</b> | 6. COLOR OR RACE<br><b>White</b> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Feb. 14, 1878</b> | 9. AGE (last birthday)<br><b>81 yrs.</b> | IF UNDER 1 YEAR<br>Months _____ Days _____ | IF UNDER 24 HR<br>Hours _____ Min. _____ |
|-----------------------|----------------------------------|---|--|--|--|--|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Farmer &amp; well driller</b> | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Farm</b> | 11. BIRTHPLACE (City and state or country)<br><b>Strongstown, Pa.</b> | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b> |
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|--|---|---|
| 13a. FATHER'S NAME<br><b>Edward Carr Fleming</b> | 13b. MOTHER'S MAIDEN NAME<br><b>Harriet Martha Cramer</b> | 14. NAME OF HUSBAND OR WIFE<br><b>Clara Pearl Fleming</b> |
|--|---|---|

|   |                         |  |                              |
|---|-------------------------|--|------------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b> | 16. SOCIAL SECURITY NO. | 17. INFORMANT<br><b>Clara Pearl Fleming, St. Joseph, Mo.</b> | Address <b>1611 Prospect</b> |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Apparently natural Causes</b> |  | INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.   | DUE TO (b) <b>Investigated City Health Dept.</b> |                                  |
|  | DUE TO (c) <b>(Unattended Death)</b>             |                                  |

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| 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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
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| 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.) |
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| 20c. TIME OF INJURY<br>Hour _____ Month, Day, Year _____<br>p.m. |
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| 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.) | 20f. CITY, TOWN, OR LOCATION<br>COUNTY _____ STATE _____ |
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21. I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ and last saw him alive on \_\_\_\_\_  
Death occurred at **9:00 P** \_\_\_\_\_ m on the date stated above, and to the best of my knowledge, from the causes stated.

|   |                                       |                                   |
|---|---------------------------------------|-----------------------------------|
| 22a. SIGNATURE (Physician)<br><b>Robert W. Kieper, M.D.</b> | 22b. ADDRESS<br><b>St. Joseph, Mo</b> | 22c. DATE SIGNED<br><b>6-9-59</b> |
|---|---------------------------------------|-----------------------------------|

|  |                                   |  |  |
|--|-----------------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> | 23b. DATE<br><b>June 11, 1959</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Mora Cemetery</b> | 23d. LOCATION (City, town, or county) (State)<br><b>St. Joseph, Missouri</b> |
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| 24. FUNERAL DIRECTOR<br><b>Stoney Funeral Home</b> | ADDRESS<br><b>St. Joseph, Mo.</b> | 25. DATE RECD. BY LOCAL REG.<br><b>June 15, 1959</b> | 26. REGISTRAR'S SIGNATURE<br><b>Mrs. Clara Goodell</b> |
|--|-----------------------------------|--|--|

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Robert W. Kieper

**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 Charles E. Bennett

Licensed Embalmer No. 4677

P. O. Address St Joseph M

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.