

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-020465

FILED JUN 22 1959

Registration District No. 042 Primary Registration District No. 1000 STATE FILE NUMBER 633 Registrar's No. 633

V. S. 300
Rev. 1-57

1. PLACE OF DEATH a. COUNTY <i>Buchanan</i>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo</i> b. COUNTY <i>Buchanan</i>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Joseph</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>St. Joseph</i>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>2224 So 12th</i>		Length of stay in lb <i>5yrs</i>	d. STREET ADDRESS (If outside, give location) <i>2224 So 12th</i>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>June</i> Middle <i>Victorine</i> Last <i>Kelly</i>			4. DATE OF DEATH Month <i>June</i> Day <i>15</i> Year <i>1959</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>April 2, 1954</i>	9. AGE (In years last birthday) <i>5</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>no</i>	11. BIRTHPLACE (City and state or country) <i>St Joseph, Mo</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13a. FATHER'S NAME <i>William Kelly</i>		13b. MOTHER'S MAIDEN NAME <i>June Paden</i>		14. NAME OF HUSBAND OR WIFE <i>none</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>	17. INFORMANT <i>William Kelly</i> Address <i>St. Joseph, Mo</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>MICROCEPHALY</i>					INTERVAL BETWEEN ONSET AND DEATH <i>5/20</i>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>7531</i>					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 _____ 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 <i>Birth</i> to <i>6/15/59</i> and last saw her alive on <i>6-14-59</i> Death occurred at <i>11:40 P.M.</i> m on the date stated above; and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <i>Clement A. Shumaker</i>			22b. ADDRESS <i>St Joseph Mo</i>		22c. DATE SIGNED <i>6-16-59</i>	
23a. BURIAL, CREMATION, or REMOVAL (Specify)		23b. DATE <i>6/17/59</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>St. Joseph, Mo</i>	
24. FUNERAL DIRECTOR <i>John C. Rupp</i>		ADDRESS <i>St. Joseph, Mo</i>	25. DATE RECD. BY LOCAL REG. <i>June 19, 1959</i>	26. REGISTRAR'S SIGNATURE <i>Wm. Clark Goodell</i>		

securing the medical certification in the specific manner required by 193.140 MoRS 1949.

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

DR. CLEMENT A. SHUMAKER
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *John E. Rupp*

Licensed Embalmer No. *3986*
P.O. Address *St. Joseph*

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.