

MARI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-020515

FILED JUL 3 1959 042

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 677

STATE FILE NUMBER

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 Washington Twp.		Length of stay in 1b Life	c. CITY OR TOWN St. Joseph		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION RFD # 4		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) RFD # 4		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First JOSEPH Middle _____ Last BRUNS			4. DATE OF DEATH Month June Day 28 Year 1959		
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Oct. 9, 1867	9. AGE (last birthday) 91	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. (10) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Gen. Farming	11. BIRTHPLACE (City and state or country) Buchanan Co. Mo.		12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME Chris Bruns		13b. MOTHER'S MAIDEN NAME Catherine Schnitzius		14. NAME OF HUSBAND OR WIFE Margaret	
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. None	17. INFORMANT Address Catherine Bruns RFD # 4 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) Coronary occlusion DUE TO (b) Arteriosclerosis DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hours 20 + yrs
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 3/16/59 to 6/2/59 and last saw her/him alive on 6/2/59 Death occurred at 3:30a on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>[Signature]</i> M.D.			22b. ADDRESS 3346 Mitchell Road, St. Joseph, Mo		22c. DATE SIGNED 6/29/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE June 30, 59	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town, or county) (State) St. Joseph, Mo.	
24. FUNERAL DIRECTOR H.D. Kidenfaden & Son R.P.Y.		ADDRESS St. Joseph Mo.	25. DATE RECD. BY LOCAL REG. June 30, 1959	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

DOCUMENT

E. Peterson, M.D., MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Mr. Peterson
3306 Mitchell

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

Robert H. Zepke

Licensed Embalmer No. 3308

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.