

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-026281

FILED VS AUG 4 1959

Registration District No. 2 EQ Primary Registration District No. 3058 Registrar's No. 182 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY St. Charles		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Charles	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Charles		Length of stay in 1b 10-yrs.	c. CITY OR TOWN St. Charles Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph's Home		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 734 Clay Street Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last Susan Clare Kibler	4. DATE OF DEATH Month Day Year July 29, 1959
---	--

5. SEX F.	6. COLOR OR RACE W.	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11/21/61 98	9. AGE (last birthday) 98	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
---------------------	-------------------------------	---	--	-------------------------------------	---	----------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Cook	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) St. Charles, Mo.	12. CITIZEN OF WHAT COUNTRY U.S.
--	-----------------------------------	---	--

13a. FATHER'S NAME James Kibler	13b. MOTHER'S MAIDEN NAME Clair Conroyer	14. NAME OF HUSBAND OR WIFE
---	--	-----------------------------

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 Mrs. Emmet Kelly, 6335 Waterman Ave.	Address
---	--	--	---------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 1 hour
Conditions, if any, which gave rise to above cause (b), stating the underlying cause last.	DUE TO (b) Arteriosclerosis	7
	DUE TO (c) Senility	

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 a.m. p.m. Month, Day, Year	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 June 24, 1959 to July 29, 1959 and last saw her alive on July 27, 1959 Death occurred at 11:30 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>J. M. J. [Signature]</i> (Degree or title) MD	22b. ADDRESS 117 S. Main, St. Charles, Mo.	22c. DATE SIGNED July 29, 1959
---	--	--

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE July 31, 1959	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis, Missouri
---	-----------------------------------	---	---

24. FUNERAL DIRECTOR <i>Arthur J. Nommel</i> ADDRESS 3840 Lindell Blvd.	25. DATE RECD. BY LOCAL REG. July 30-59	26. REGISTRAR'S SIGNATURE <i>Marella Wilson</i>
---	---	--

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 by
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Francis Miller

Licensed Embalmer No. 356

P. O. Address 3840

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