

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-031503

FILED VS SEP 21 1959

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 923

STATE FILE NUMBER

BY AFFIDAVIT OF DOCUMENT

|  |  |   |  |   |  |  |   |
|--|--|---|--|---|--|--|---|
| 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>Iowa</b> b. COUNTY <b>Des Moines</b> |  |  |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>St. Joseph</b>   |  | Length of stay in 1b<br><b>1 day</b>  |  | c. CITY OR TOWN <b>Burlington</b>   |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>D.O.A. Mo. Meth. Hosp.</b>   |  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location)<br><b>515 N. Plane</b>  |  |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <b>MAHLEON</b> Middle <b>GERALD</b> Last <b>COUNTER</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>Sept.</b> Day <b>9,</b> Year <b>1959</b>   |  |  |   |
| 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>10/21/1911</b>   | 9. AGE (last birthday) <b>47</b>   | IF UNDER 1 YEAR<br>Months Days Hours Min.  | IF UNDER 24 HR  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Maintenance Engineer</b>   |  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Railroad Co.</b>                             |   | 11. BIRTHPLACE (City and state or country)<br><b>Selden, Kansas</b>  |  | 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b>   |
| 13a. FATHER'S NAME<br><b>N. L. Counter</b>   |  |   | 13b. MOTHER'S MAIDEN NAME<br><b>Bessie B. Baner</b>                                  |   | 14. NAME OF HUSBAND OR WIFE<br><b>Katherine Counter</b>  |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>   |  |   | 16. SOCIAL SECURITY NO.<br><b>707-05-2246</b>  | 17. INFORMANT<br>Address <b>Burlington</b><br><b>Mrs. M.G. Counter, 515 N. Plane, Iowa</b>  |  |  |   |
| 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>Unattended Death - Natural Causes</b><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Investigated by City Health Dept.</b><br>DUE TO (c) |  |   |  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH  |
| 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 |  |   |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour a.m. p.m.  |  | Month, Day, Year  |  |   |  |  |   |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/><br>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 _____ to _____ and last saw her/him alive on _____<br>Death occurred at <b>11:30 A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.   |  |   |  |   |  |  |   |
| 22a. SIGNATURE (Inscribed or title)<br><b>Robert F. Kiebert M.D.</b>   |  |   |  | 22b. ADDRESS<br><b>St. Joseph, Mo</b>   |  | 22c. DATE SIGNED<br><b>9-9-59</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>removal</b>  | 23b. DATE<br><b>9/9/1959</b>           | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City, town, or county)<br><b>Burlington Iowa</b>   |  | (State)  |   |
| 24. FUNERAL DIRECTOR<br><b>Hedon-Bauman</b>  |  |   | ADDRESS<br><b>St. Joseph, Mo.</b>  | 25. DATE RECD. BY LOCAL REG.<br><b>Sept 14, 1959</b>  | 26. REGISTRAR'S SIGNATURE<br><b>Wm. Clark Goodell</b>  |  |   |

R.W. Kiebert, M.D. MEDICAL CERTIFICATION

8961 2 8 298

*Handwritten notes:*  
Have been  
Karl's [unclear]

**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 Eugene Wood

Licensed Embalmer No. 3804

P. O. Address 319 1/2 10th St.

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.