

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-031514

FILED VS SEP 28 1959

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STATE FILE NUMBER

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

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) St. Joseph, Missouri		Length of stay in lb 1 day		c. CITY OR TOWN St. Joseph, Missouri		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>					
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Missouri Methodist Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS 2820 Lafayette St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First MARGARET Middle EMMA Last FRY				4. DATE OF DEATH Month September Day 15 Year 1959							
5. SEX Female		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 June 22, 1887		9. AGE (last birthday) 72			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (City and state or country) Avilla, Kansas		12. CITIZEN OF WHAT COUNTRY USA		IF UNDER 1 YEAR Months Days Hours Min.			
13a. FATHER'S NAME Wm. Lee Marks			13b. MOTHER'S MAIDEN NAME Ella Owens			14. NAME OF HUSBAND OR WIFE Grover A. Fry			Address		
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. No		17. INFORMANT Mr. William A. Fry 504 Orchard Lane						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Artery Disease								INTERVAL BETWEEN ONSET AND DEATH 36 hr.			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) Old Hypertensive Cardio-Renal Vascular Disease (yrs)									
		DUE TO (c) Myocardial Infarction									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Atherosclerosis Ilen						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 2-18-57 to 9-15-59 and last saw ^{her} _{him} alive on 9-15-59 Death occurred at 6:15 PM m on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE (Deceased or title) Robert W. Kieber, M.D.				22b. ADDRESS St. Joseph, Mo				22c. DATE SIGNED 9-16-59		(State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Sept 17, 1959		23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery		23d. LOCATION (City, town, or county) St. Joseph, Missouri					
24. FUNERAL DIRECTOR Hector Bowman				ADDRESS St. Joseph, Missouri		25. DATE RECD. BY LOCAL REG. Sept. 18, 1959		26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell			

DOCUMENT

BY AFFIDAVIT OF R.W. Kieber, M.D. 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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Eugene Wood

Licensed Embalmer No. 3807

P. O. Address 319 South 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.