

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-031557

FILED VS OCT 13 1959 042

Registration District No. Primary Registration District No. 1000 Registrar's No. 1001

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY Buchanan				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Buchanan					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in 1b 61 years		c. CITY OR TOWN St. Joseph		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. Francis Hotel			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) St. Francis Hotel			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle F. Last QUANEY				4. DATE OF DEATH Month Sept. Day 30, Year 1959					
5. SEX male	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH July 19, 1891	9. AGE (last birthday) 78	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Bookkeeper			10b. KIND OF BUSINESS OR INDUSTRY City & County Offices		11. BIRTHPLACE (City and state or country) Macomb, Illinois		12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME Charles D. Quaney			13b. MOTHER'S MAIDEN NAME Mary Burke			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. unknown		17. INFORMANT Mrs. Mary S. Thompson, 320 N. 20th St. Joseph, 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) Unattended Death - natural Causes Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. Investigated by Health Dept. 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) 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 _____ to _____ and last saw her/him alive on _____ Death occurred at 10:00 a. m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE Robert W. Kieber, M.D.				22b. ADDRESS St. Joseph, Mo.			22c. DATE SIGNED 10-3-59		
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 10/2/1959	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town, or county) St. Joseph		STATE Mo.			
24. FUNERAL DIRECTOR Newton Bowman				ADDRESS St. Joseph, Mo.		25. DATE RECD. BY LOCAL REG. Oct. 7, 1959		26. REGISTRAR'S SIGNATURE Wm. Clark Stoddell	

DOCUMENT

MEDICAL CERTIFICATION
P.W. Kieber M.D.

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 Eugene Wood

Licensed Embalmer No. 3804

P. O. Address 319 So 10th St

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.