

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

# 59-031565

## FILED VS. SEP 28 1959

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STATE FILE NUMBER

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

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Buchanan</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>		Length of stay in 1b		c. CITY OR TOWN <b>St. Joseph</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>518 1/2 So. 6th St.</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>518 1/2 So. 6th St.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>CLEO</b> Middle <b>STEPHEN</b> Last <b>STIVERSON</b>				<b>4. DATE OF DEATH</b> Month <b>Sept.</b> Day <b>17</b> Year <b>1959</b>				
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input checked="" type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>6-24-1901</b>	<b>9. AGE (last birthday)</b> <b>58</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Cook</b>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Ranch</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>Coin Iowa</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U S A</b>	
<b>13a. FATHER'S NAME</b> <b>David Stiverson</b>			<b>13b. MOTHER'S MAIDEN NAME</b> <b>Mary Smith</b>			<b>14. NAME OF HUSBAND OR WIFE</b> <b>None</b>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes W.W. #1</b>			<b>16. SOCIAL SECURITY NO.</b> <b>523-05-9373</b>		<b>17. INFORMANT</b> <b>Mrs. Ethel Woldroff</b>			Address <b>Clarinda, Iowa</b>
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage of a cerebral vessel</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Stone</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Falling and striking head on curb</b>							<b>Stone</b>	
DUE TO (c) <b>Being struck while fighting</b>							<b>Stone</b>	
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		
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input checked="" type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) <b>Edible Aggressor in fist fight</b>						
<b>20c. TIME OF INJURY</b> <b>930</b> p.m. <b>Sept 17-59</b> <b>Street 51886</b> <b>St Joe</b>	<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Buchanan MO</b>		<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY _____ STATE _____				
<b>21. I attended the deceased from</b> <b>mailed bodies</b> <b>and last saw him alive on</b> <b>Sept 18 59</b> Death occurred at <b>3:30P</b> m on the date stated above, and to the best of my knowledge, from the causes stated.								
<b>22a. SIGNATURE</b> (Degree or title) <b>SE Melaney MD Coroner</b>				<b>22b. ADDRESS</b> <b>St Joe Buchanan Co</b> <b>144 Kentucky Bldg</b>		<b>22c. DATE SIGNED</b> <b>7/28/59</b>		
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Removal</b>		<b>23b. DATE</b> <b>9-18-59</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Clarinda</b>			<b>23d. LOCATION (City, town, or county)</b> <b>Iowa</b>		
<b>24. FUNERAL DIRECTOR</b> <b>Walker Funeral Home</b> <b>Clarinda, Iowa</b>				<b>25. DATE RECD. BY LOCAL REG.</b> <b>Sept. 22, 1959</b>		<b>26. REGISTRAR'S SIGNATURE</b> <b>Mrs. Clark Woodell</b>		

DOCUMENT

SE Melaney, M.D. Medical Certification

BY AFFIDAVIT OF

