

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-039046

FILED VS DEC 14 1959 042

STATE FILE NUMBER

Registration District No. Primary Registration District No. 1000 Registrar's No. 1242

INDEXED

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) OR TOWN St. Joseph		Length of stay in lb Life		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. Joseph's Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1611 Savannah Ave.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Nona Middle Last Raidt				4. DATE OF DEATH Month December Day 8, Year 1959				
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH Aug. 10, 1936	9. AGE (last birthday) 73	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) Housewife			10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (City and state or country) St. Joseph, Mo.		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Thomas Hayes			13b. MOTHER'S MAIDEN NAME Jenny Flanagan			14. NAME OF HUSBAND OR WIFE Emmett T. Raidt		
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 Address Emmett T. Raidt 1611 Savannah Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EMBOLUS</u> DUE TO (b) <u>FRACTURED LEFT HIP</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>2 MIN.</u> <u>11 DAYS.</u>	
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 SUICIDE HOMICIDE <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>SLIPPED FALLING ON HIP</u>				
20c. TIME OF INJURY Hour 2 a.m.		Month, Day, Year <u>11-28-59</u>						
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>HOME</u>		20f. CITY, TOWN, OR LOCATION <u>1611 SAVANNAH ST JOSEPH BUCHANAN, MO.</u>		COUNTY STATE		
21. I attended the deceased from <u>NOV. 28, 1959</u> to <u>DEC. 8, 1959</u> and last saw her/him alive on <u>DEC. 8, 1959</u> Death occurred at <u>5:30a</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>[Signature]</u> (Degree or title)				22b. ADDRESS <u>302 Faram St Joseph</u>			22c. DATE SIGNED <u>12-10-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>12-11-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>			23d. LOCATION (City, town, or county) (State) <u>St. Joseph, Mo.</u>		
24. FUNERAL DIRECTOR <u>H.D. Siderfahn & Son</u> ADDRESS <u>St Joseph, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>Dec. 11, 1959</u>		26. REGISTRAR'S SIGNATURE <u>Mr. Clark Gendell</u>		

DOCUMENT

BY AFFIDAVIT OF

L.H. Pifer, M.D. MEDICAL CERTIFICATION

Bayer

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Robert H. Goble*

Licensed Embalmer No. 3308

P. O. Address *St Joseph, Mo*

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.