

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-039278

FILED VS. NOV 25 1959

STATE FILE NUMBER

Registration District No. 59 Primary Registration District No. _____ Registrar's No. 176

1. PLACE OF DEATH a. COUNTY <u>CASS</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>CASS</u>				
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>West Peculiar Twp.</u>		Length of stay in 1b _____		c. CITY OR TOWN <u>GRAND VIEW</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>U.S. Highway 71</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (if outside, give location) <u>RICHARDS-GEAR Air Force Base</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES JOHN DOCKENDORF</u>				4. DATE OF DEATH Month Day Year <u>Nov. 15 1959</u>				
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>9-21-1939</u>	9. AGE (last birthday) <u>20</u>	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) <u>AIR MAN</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. AIR FORCE</u>		11. BIRTHPLACE (City and state or country) <u>WATKINS MINN.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	
13a. FATHER'S NAME <u>WENDEL DOCKENDORF</u>			13b. MOTHER'S MAIDEN NAME <u>STEPHANIE HALL BRENNER</u>			14. NAME OF HUSBAND OR WIFE <u>None -</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes - 1959 AF 1957-1968</u>			16. SOCIAL SECURITY NO. <u>471-38-7613</u>		17. INFORMANT <u>Military Records Richard Gear AFB Mo.</u>			Address <u>GRAND VIEW</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH CAUSED BY:							INTERVAL BETWEEN DEATH AND DEATH <u>Scoble</u>	
IMMEDIATE CAUSE (a) <u>Brain Trauma</u>			DUE TO (b) <u>fractured skull</u>					
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (c) <u>auto accident</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 <input checked="" 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.) <u>auto accident</u>					
20c. TIME OF INJURY Hour a.m. p.m. <u>11-15-1959</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>Highway</u>		20f. CITY, TOWN, OR LOCATION <u>West Peculiar Township</u>		COUNTY <u>CASS</u>		STATE <u>Missouri</u>
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at <u>3 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>John Stebbin Sheriff Acc Comm</u>				22b. ADDRESS <u>208 W. Pearl Hill</u>			22c. DATE SIGNED <u>11-15-59</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>11-15-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. ANTHONY Cemetery WATKINS MINNESOTA</u>			23d. LOCATION (City, town, or county) (State)		
24. FUNERAL DIRECTOR <u>Sheil Funeral Home - Kansas City, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>11-16-59</u>		26. REGISTRAR'S SIGNATURE <u>Mar Ray Sebree</u>		

DOCUMENT

MEDICAL CERTIFICATION

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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Robert W. Johnson

Licensed Embalmer No. 4902

P. O. Address Hammond, La.

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.