

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

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STATE FILE NUMBER

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

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|--|--|---|---|--|---|--|--|-------------------------------------|---------|--|
| 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 lo yrs | | 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 | | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS 2508 So 10th | | (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Amanda Coontz | | | | 4. DATE OF DEATH Dec 21, 1959 | | | | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> ? Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH Nov 5, 1893 | | 9. AGE (last birthday) 66 | | |
| | | | | | | 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) House keeper | | | 10b. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (City and state or country) Stone Co, Mo | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | | | |
| 13a. FATHER'S NAME A.F. Hilton | | | 13b. MOTHER'S MAIDEN NAME Unk | | | 14. NAME OF HUSBAND OR WIFE None | | | | |
| 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 Welfare records | | | | 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 Cause Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. Investigated by City Health Dept. DUE TO (b) DUE TO (c) | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| 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 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 Month, Day, Year a.m. p.m. | | | | | | | | | | |
| 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 6:10 A m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | |
| 22a. SIGNATURE OF DECEASED Robert W Kieber, M.D. | | | | 22b. ADDRESS St. Joseph, Mo | | | | 22c. DATE SIGNED 12-24-59 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 12/23/1959 | | 23c. NAME OF CEMETERY OR CREMATORY Sunbridge Cemetery | | 23d. LOCATION (City, town, or county) (State) St. Joseph, Missouri | | | | |
| 24. FUNERAL DIRECTOR John Rupp | | | ADDRESS St. Joseph, Mo | | 25. DATE RECD. BY LOCAL REG. Dec. 30, 1959 | | 26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell | | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

