

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS FEB 6 1960

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-60-000278

STATE FILE NUMBER

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

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 1b 5 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 St. Joseph's Hosp.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 801 North 10th		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First AMELIA Middle _____ Last BRUNS				4. DATE OF DEATH Month February Day 2, Year 1960			
5. SEX Female		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 5-15-1880	
9. AGE (last birthday) 79		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HR Months _____ Days _____ Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home			10b. KIND OF BUSINESS OR INDUSTRY Housework		11. BIRTHPLACE (City and state or country) Savannah, Mo.		12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME Chris Bruns			13b. MOTHER'S MAIDEN NAME Catherine Schnitzius			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 Mrs Gerald Morelock Address St. Joseph, Mo.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerosis 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							INTERVAL BETWEEN ONSET AND DEATH 5 days ?
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 _____ s.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 1-28-60 to 2-1-60 and last saw her alive on 2-1-60 Death occurred at 8:05a on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Deaf or title) J.L. Mothershead				22b. ADDRESS 2603 Friedrich			22c. DATE SIGNED 2-3-60
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Feb. 4, 1960	23c. NAME OF CEMETERY OR CREMATORY Savannah Cemetery		23d. LOCATION (City, town, or county) (State) Savannah, Mo.		
24. FUNERAL DIRECTOR H.O. Sidenfaden & Son			ADDRESS St. Joseph, Mo.		25. DATE RECD. BY LOCAL REG. Feb. 3, 1960		26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell

DOCUMENT

BY AFFIDAVIT OF J.L. Mothershead (Deaf or title)

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

Robert H. Gaylor

Licensed Embalmer No. 3303

P. O. Address St. Joseph, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.