

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. FEB 1 1960 042

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=60-000286

STATE FILE NUMBER

390

DED

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 St. Joseph		Length of stay in 1b 14 days		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 Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1416 Sacramento Street		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROBERT Middle OWEN Last CARSON				4. DATE OF DEATH Month January , Day 23 , Year 1960				
5. SEX Male	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 1/10/1960	9. AGE (last birthday) —	IF UNDER 1 YEAR Months — Days 14	IF UNDER 24 HR Hours — Min. —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (City and state or country) St. Joseph, Missouri		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME Clifford L. Carson			13b. MOTHER'S MAIDEN NAME Patsy Harrison		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 Clifford L. Carson, 1416 Sacramento Street, 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) Acute Infectious Diarrhea = Disease Colon (Type?)						INTERVAL BETWEEN ONSET AND DEATH 7 Days		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ 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			
19. WAS AUTOPSY PERFORMED? YES <input checked="" 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 _____								
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 1-10-60 to 1-23-60 and last saw ^{her} him _{live} on 1-23-60 Death occurred at 11:50 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE Robert W. Kieber, M.D. (Dr. or title)			22b. ADDRESS St. Joseph, Mo			22c. DATE SIGNED 1-25-60		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 1/25/1960	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery		23d. LOCATION (City, town, or county) St. Joseph, Missouri				
24. FUNERAL DIRECTOR Stoney Funeral Home (GAS)		ADDRESS St. Joseph, Mo.		25. DATE RECD. BY LOCAL REG. Jan 27, 1960	26. REGISTRAR'S SIGNATURE Wm. Clark Goodell			

DOCUMENT

BY AFFIDAVIT OF

R.W. Kieber, M.D. MEDICAL CERTIFICATION

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 *Embalmer*

Licensed Embalmer No. 4238

P. O. Address *H. Gray*

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.