

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-000320

FILED VS FEB 15 1960

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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 Mo. b. COUNTY Clinton									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in 1b minutes		c. CITY OR TOWN Cameron		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DOA St. Joseph's Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 718 W.6th		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First GORDON Middle OWEN Last GRAHAM				4. DATE OF DEATH Month Feb. Day 5, Year 1960									
5. SEX male		6. COLOR OR RACE W		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH June 26 1904		9. AGE (last birthday) 55		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) Furniture Store				10b. KIND OF BUSINESS OR INDUSTRY Used Furniture		11. BIRTHPLACE (City and state or country) Clinton Co. Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.					
13a. FATHER'S NAME W. T. Graham				13b. MOTHER'S MAIDEN NAME Leona Rounds				14. NAME OF HUSBAND OR WIFE Anna Graham					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) No None				16. SOCIAL SECURITY NO. 483-07-6927		17. INFORMANT Mrs. Gordon Graham Cameron 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) Unattended Death - natural Causes. DUE TO (b) Investigated by City Health Dept. DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.													
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 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 _____ a.m. _____ p.m.		Month, Day, Year _____											
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.)			20f. CITY, TOWN, OR LOCATION		COUNTY		STATE				
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____. Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Typed Name) Robert Neuberger MD.						22b. ADDRESS St. Joseph, Mo			22c. DATE SIGNED 2-11-60				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Feb. 8 1960		23c. NAME OF CEMETERY OR CREMATORY Graceland Cemetery				23d. LOCATION (City, town, or county) Cameron Mo					
24. FUNERAL DIRECTOR Poland Funeral Home Cameron Mo.				ADDRESS		25. DATE RECD. BY LOCAL REG. Feb. 12, 1960		26. REGISTRAR'S SIGNATURE Mrs. Clark Standell					

DOCUMENT

BY MEDICAL CERTIFICATION
R. Neuberger, M.D.

BY AFFIDAVIT OF

FEB 24 1980

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 L. Paloud

Licensed Embalmer No. 4777
222 west 2
P. O. Address Bromer

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.