

**DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**=60-000341**

**ED VS FEB 8 1960**

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STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Buchanan</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>		Length of stay in 1b <b>80 years</b>	c. CITY OR TOWN <b>St. Joseph</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Wilson Nursing Home 611 N. 11th St.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>611 N. 11th St.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>METTA</b> Middle <b>E.</b> Last <b>KAUTZ</b>		4. DATE OF DEATH Month <b>January</b> Day <b>29</b> Year <b>1960</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>6/21/1878</b>
9. AGE (last birthday) <b>81</b>		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) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	11. BIRTHPLACE (City and state or country) <b>Chincoteague, Va.</b>
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13a. FATHER'S NAME <b>Charles O. Disbrow</b>	
13b. MOTHER'S MAIDEN NAME <b>Caroline Jones</b>		14. NAME OF HUSBAND OR WIFE <b>Herman H. Kautz</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	17. INFORMANT <b>Heaton-Bowman Pre-arranged Records</b> 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) <b>Cerebral Hemorrhage</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Unk.</b>
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 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 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 <b>1/16/60</b> to <b>1/29/60</b> and last saw <sup>her</sup> <del>him</del> alive on <b>1/28/60</b>		Death occurred at <b>2:30a.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <b>[Signature]</b>		22b. ADDRESS <b>Social Welfare Board 10th &amp; Olive, St. Joseph, Mo.</b>	22c. DATE SIGNED <b>1/30/60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>2/1/1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ashland Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Joseph Mo.</b>
24. FUNERAL DIRECTOR <b>Heaton-Bowman</b>		ADDRESS <b>St. Joseph, Mol</b>	25. DATE RECD. BY LOCAL REG. <b>Feb. 2, 1960</b>
		26. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

DOCUMENT

BY AFFIDAVIT OF St. Melvyn M. Medical Certification

BY AFFIDAVIT OF

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**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 William Spudis

Licensed Embalmer No. 45-31

P. O. Address Joseph

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.