

REGISTRATION DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-000344

FILED VS FEB 1 1960 042

Registration District No. _____ Primary Registration District No. 1000 Registrar's No. 95

STATE FILE NUMBER

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 23 years		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 819 1/2 S. 8th St.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 819 1/2 S. 8th St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First MIDDLE Last RICHARD RAY KLINE				4. DATE OF DEATH Month Day Year January 22, 1960					
5. SEX male	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH May 21, 1909	9. AGE (last birthday) 50	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) Laborer			10b. KIND OF BUSINESS OR INDUSTRY City Park Dept.		11. BIRTHPLACE (City and state or country) Bourbon Co., Kentucky		12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME Elick Cline			13b. MOTHER'S MAIDEN NAME Rosa B. May			14. NAME OF HUSBAND OR WIFE Bertha Kline			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give way or dates of service) yes W.W. # 11			16. SOCIAL SECURITY NO. 491-10-7510		17. INFORMANT Mrs. Bertha Kline, 819 1/2 S. 8th, 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) <u>Natural Causes - Unattended Death</u> DUE TO (b) <u>Investigated by City Health Dept.</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.								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 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 _____ to _____ and last saw her/him alive on _____ Death occurred at _____ 10:00 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (City Health Officer) Robert W. Kieber M.D.				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 Dearborn Masonic Cemetery			23d. LOCATION (City, town, or county) (State) Dearborn, Missouri			
24. FUNERAL DIRECTOR Heaton Bowman, St. Joseph, Mo.				25. DATE RECD. BY LOCAL REG. Jan. 28, 1960		26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell			

DOCUMENT

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

BY AFFIDAVIT OF

FEB 4

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 Spackling

Licensed Embalmer No. 4525

P. O. Address St Joseph

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