

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

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~~60-000355~~

STATE FILE NUMBER

60-000355

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

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|--|--|---|---|---|---|--|---|--|
| 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 2Mo | | 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 D.O.A. Mo. Meth. Hosp. | | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 202 1/2 E Kansas Ave | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Lillian Middle Sue Last McNamara | | | | 4. DATE OF DEATH Month Jan. Day 25, 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 Nov. 24, 1959 | | |
| 9. AGE (last birthday) 2 Months 1 Days | | IF UNDER 1 YEAR Months 2 Days 1 | | IF UNDER 24 HR Hours 1 Min. 0 | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child | | | 10b. KIND OF BUSINESS OR INDUSTRY no | | 11. BIRTHPLACE (City and state or country) St. Joseph, Mo | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13a. FATHER'S NAME Thomas R. McNamara | | | 13b. MOTHER'S MAIDEN NAME Lillie Hathaway | | | 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 Thomas R McNamara 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) Natural Causes - Unattended Death 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 checked="" 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 _____ on the date stated above, and to the best of my knowledge, from the causes stated. Death occurred at 10:30 A.M. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE Robert McKee, MD | | | | 22b. ADDRESS St. Joseph, Mo | | 22c. DATE SIGNED 1-26-60 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE 1/27/60 | | 23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery St. Joseph, Mo | | 23d. LOCATION (City, town, or county) (State) | | |
| 24. FUNERAL DIRECTOR Phu Keepest ADDRESS St. Joseph, Mo | | 25. DATE RECD. BY LOCAL REG. Jan. 28, 1960 | | 26. REGISTRAR'S SIGNATURE Mrs Clark Standell | | | | |

DOCUMENT

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

BY AFFIDAVIT OF

