

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-005220

FILED VS FEB 29 1960 042

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STATE FILE NUMBER

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

DED

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 37 yrs		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 2823 Seneca			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS 114 So 19th (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First David Middle Kasselhute Last				4. DATE OF DEATH Month Feb. Day 18, Year 1960					
5. SEX Male		6. COLOR OR RACE White		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>		8. DATE OF BIRTH Mar. 7, 1922		9. AGE (last birthday) 37	
						IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman			10b. KIND OF BUSINESS OR INDUSTRY Drug Co		11. BIRTHPLACE (City and state or country) St. Joseph, Mo		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME Roy Kasselhute			13b. MOTHER'S MAIDEN NAME Cora O'Dell			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.		17. INFORMANT Address Cora Kasselhute 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) <i>Natural Causes - Unattended Death -</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Investigated by City Health Dept</i> DUE TO (c)								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 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 Month, Day, Year a.m. p.m.									
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 <u>2/18/60</u> and last saw her/him live on _____. Death occurred at <u>9:00 A.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <i>Robert W Kieber M.D.</i>				22b. ADDRESS <i>St. Joseph Mo</i>				22c. DATE SIGNED <i>2-19-60</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		23b. DATE <i>2/20/60</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Moray Cemetery</i>		23d. LOCATION (City, town, or county) <i>Moray Kansas</i>		(State)	
24. FLUNERAL DIRECTOR <i>John E. Sapp</i>				ADDRESS <i>St. Joseph, Mo</i>		25. DATE RECD. BY LOCAL REG. <i>Feb. 19, 1960</i>		26. REGISTRAR'S SIGNATURE <i>Wm. Clark Goodell</i>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF *R.W. Kieber, M.D.*

