

VIRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-005262

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STATE FILE NUMBER

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

1. PLACE OF DEATH a. COUNTY Buchanan b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph Length of stay in 1b 15 years. c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph's Hospital Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan c. CITY OR TOWN St. Joseph Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) 1328 S. 15th St. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mae Middle Oliver Last Roberts			4. DATE OF DEATH Month February Day 28 Year 1960				
5. SEX Female	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 Mar. 13, 1881	9. AGE (last birthday) 78	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) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (City and state or country) Conception, Missouri, USA		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME George M. Kuhn			13b. MOTHER'S MAIDEN NAME Elizabeth Ann Graves		14. NAME OF HUSBAND OR WIFE Clarence Roberts		
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 Address Leonard S. Proztman-Conception, 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) Cerebral Vasalar Accident Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Old Hypertensive Cardio Renal Vasalar Disease - Yes DUE TO (c) Old Arteriosclerosis Gen - Yes PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not listed to the terminal disease condition given in PART I (a) Diabetes mellitus 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						INTERVAL BETWEEN ONSET AND DEATH 2 PM	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 Nov. 1, 1955 to Feb. 28, 1960 and last saw her/him alive on Feb. 28, 1960 Death occurred at 3:15 P. m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Robert W. Kieber, M.D.				22b. ADDRESS St. Joseph, Mo		22c. DATE SIGNED 3-1-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE Febr. 29, 1960	23c. NAME OF CEMETERY OR CREMATORY St. Columba Cemetery		23d. LOCATION (City, town, or county) (State) Conception, Missouri.		
24. FUNERAL DIRECTOR ADDRESS St. Joseph, Mo.			25. DATE RECD. BY LOCAL REG. Mar. 4, 1960		26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell		

DOCUMENT

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

BY AFFIDAVIT OF

MAY 17 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 E. Lawrence

Licensed Embalmer No. 3250

P. O. Address H. Jones

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.