

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-005266

FILED VS MAR 14 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 lb <b>52 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>Mo. Methodist Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1820 Savannah Ave.</b>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>FLOYD</b> Middle <b>H.</b> Last <b>SCHILLING</b>				4. DATE OF DEATH Month <b>March</b> Day <b>3</b> Year <b>1960</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>2/7/1904</b>	9. AGE (last birthday) <b>56</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>Traffic manager</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Chemical Company</b>		11. BIRTHPLACE (City and state or country) <b>Chippewa Falls, Wisc.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>unknown</b>			13b. MOTHER'S MAIDEN NAME <b>unknown</b>			14. NAME OF HUSBAND OR WIFE <b>Beulah</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 Address <b>St. Joseph, Mo.</b> <b>Mrs. Floyd Schilling, 1820 Savannah Ave.</b>		
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>Agatemia (Uremia.)</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Chronic pyelonephritis</b> DUE TO (c) <b>Neurologic fistula</b>						INTERVAL BETWEEN ONSET AND DEATH <b>30 days</b> <b>several months</b> <b>several months</b>	
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"/> N. <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 <b>248</b>		COUNTY _____ STATE _____	
21. I attended the deceased from <b>1-12-60</b> to <b>3-3-60</b> and last saw her/him alive on <b>3-3-60</b> Death occurred at <b>2:00 a.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22. SIGNATURE (Degree or title) <b>Luce W. Ide M.D.</b>				22b. ADDRESS <b>902 Edmund St. Joseph, Mo.</b>		22c. DATE SIGNED <b>3-3-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>3/5/1960</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, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>Mar. 9 1960</b>	26. REGISTRAR'S SIGNATURE <b>Wm. Clark Standell</b>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FEB 15 1961.

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 Eugene Wood

Licensed Embalmer No. 3804

P. O. Address 319 56th St. N.

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.