

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-005272

FILED VS. FEB 29 1960 042

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STATE FILE NUMBER

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

| | | | | | | | | |
|--|--|---|--|---|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Buchanan | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph | | Length of stay in 1b | | 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 Sisters Hospital | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 1923 Savannah Ave. | | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First William Middle Albert Last Stendiford | | | | 4. DATE OF DEATH Month 2 Day 23 Year 1960 | | | | |
| 5. SEX male | 6. COLOR OR RACE white | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 8-5-75 | 9. AGE (last birthday) 84 | 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) Inspector | | 10b. KIND OF BUSINESS OR INDUSTRY Health Dept. | | 11. BIRTHPLACE (City and state or country) Camden Point, Mo. | | 12. CITIZEN OF WHAT COUNTRY USA | | |
| 13a. FATHER'S NAME John E. Stendiford | | | 13b. MOTHER'S MAIDEN NAME Margaret Bywaters | | 14. NAME OF HUSBAND OR WIFE Eugene | | | |
| 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. 499-36-5303 | | 17. INFORMANT Address Mrs. Fred Gustin Dearborn, 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 Vascular Accidents - Arteriosclerosis Sen - Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH 10 Days | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Senility | | | | | 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 1951 to 2-23-60 and last saw ^{her} him alive on 2-23-60 Death occurred at 5:00 P m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE Robert W. Kieber MD | | | 22b. ADDRESS St. Joseph, Mo | | 22c. DATE SIGNED 2-24-60 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE 2-25-60 | 23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cem. St. Joseph, Missouri | | 23d. LOCATION (City, town, or county) St. Joseph, Missouri | | 23e. (State) | | |
| 24. FUNERAL DIRECTOR Vaughn-Aufranc | | ADDRESS Dearborn, Mo. | | 25. DATE RECD. BY LOCAL REG. Feb. 24, 1960 | 26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell | | | |

DOCUMENT

BY AFFIDAVIT OF MEDICAL CERTIFICATION
R.W. Kieber, M.D.

BY AFFIDAVIT OF

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 W. R. Vaughn

Licensed Embalmer No. 4023

P. O. Address Weston

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