

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-005278

FILED VS FEB 23 1960 042

Registration District No. Primary Registration District No. 1000 Registrar's No. 185

STATE FILE NUMBER

INDEXED

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 Life		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 St. Joseph's Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 715 South 16th		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First LEONA Middle CECELIA Last TOOLE				4. DATE OF DEATH Month February Day 10 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 1-24-1891	9. AGE (last birthday) 69	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher			10b. KIND OF BUSINESS OR INDUSTRY Public Schools		11. BIRTHPLACE (City and state or country) St. Joseph, Mo.		12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME Charles E. Toole			13b. MOTHER'S MAIDEN NAME Cecelia Marcinkowski			14. NAME OF HUSBAND OR WIFE None			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (No)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Marie Toole 715 So. 16th City					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Interstitial Pneumonia							INTERVAL BETWEEN ONSET AND DEATH 10 days		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Influenza							5 days		
DUE TO (c)									
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"/> 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 s.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 1-30-60 to 2-10-60 and last saw her 2-10-60 Death occurred at 10:00pm on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Deceased or Title) Walter C. Siderofsky				22b. ADDRESS St. Joseph, Mo.				22c. DATE SIGNED 2-12-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Feb. 13, 1960	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town, or county) St. Joseph, Mo.		23e. STATE Mo.			
24. FUNERAL DIRECTOR H. O. Siderofsky & Son			ADDRESS St. Joseph, Mo.		25. DATE RECD. BY LOCAL REG. Feb. 12, 1960		26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell		

DOCUMENT

C.C. DeMont M.D. MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Summit

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 H. Gaylor*

Licensed Embalmer No. 3308

P. O. Address St. Joseph, Mo.

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.