

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-014227

FILED VS APR 18 1960

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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 most of 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 2423 Messanie St.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2423 Messanie St.

3. NAME OF DECEASED (Type or print) First MARGARET Middle C. Last MYERS BILLER	4. DATE OF DEATH Month April Day 9 Year 1960
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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 12/6/1895	9. AGE (last birthday) 64	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (City and state or country) Ottumwa, Iowa	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME Charles J. Myers	13b. MOTHER'S MAIDEN NAME Helen Rowland	14. NAME OF HUSBAND OR WIFE Bernard Biller
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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. unknown	17. INFORMANT Address Bernard Biller, 2423 Messanie, St. Joseph, Mo.
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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 Hemorrhage	INTERVAL BETWEEN ONSET AND DEATH 6 hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Carcinoma of bowel resected 1956	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
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year
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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 St. Joseph	COUNTY Buchanan	STATE Mo.
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21. I attended the deceased from **Aug 1956** to **April 9 1960** and last saw her alive on **April 9 1960**
Death occurred at **7:15 p.** m on the date stated above, and to the best of my knowledge, from the causes stated.

21a. SIGNATURE (Degree or title) J.L. Mothenhead M.D.	22b. ADDRESS 2603 Fredrick	22c. DATE SIGNED 4-13-60
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23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 4/12/1960	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	23d. LOCATION (City, town, or county) (State) St. Joseph Mo.
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24. FUNERAL DIRECTOR ADDRESS Heston-Bowman, St. Joseph, Mo.	25. DATE RECD. BY LOCAL REG. April 14 1960	26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell
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DOCUMENT

J.L. Mothenhead Medical Certification

BY AFFIDAVIT OF

OCT 27 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 William Spedding

Licensed Embalmer No. 4535

P. O. Address St Joseph

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.