

**MRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-014277**

**FILED VS. MAY 9 1960**

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526

STATE FILE NUMBER

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 1b <b>50yrs</b>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Joseph Hosp.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. STREET ADDRESS <b>627 Alabama</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Eiaz Piza</b> Middle <b>Kalaturka</b> Last		4. DATE OF DEATH Month <b>April</b> Day <b>29</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>April 12, 1900</b>
9. AGE (last birthday) <b>60</b>		IF UNDER 1 YEAR Months <b>60</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (City and state or country) <b>Austria</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME <b>Leo P Ripak</b>	
13b. MOTHER'S MAIDEN NAME <b>Mary ??</b>		14. NAME OF HUSBAND OR WIFE <b>nester Kalaturka (de)</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>none</b>	
17. INFORMANT <b>Frances McCullough</b>		Address <b>St. Joseph, Mo</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>Arterio-sclerosis - renal. Renal failure</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
DUE TO (b) <b>Arteriosclerosis - general - Hypertensive</b>			
DUE TO (c) <b>Gangrene - left leg. Amputation on Apr 26, '60</b>			<b>3 days</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 checked="" 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 <b>6:40</b> a.m. <b>P.M.</b> 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 <b>June 15, '51</b> to <b>April 29, 1960</b> and last saw her alive on _____ Death occurred at <b>6:40 P.M.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>C.S. Grant M.D.</b> (Degree or title)		22b. ADDRESS <b>St. Joseph, Mo</b>	22c. DATE SIGNED <b>5-3-60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>5/2/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Joseph, Mo</b>
24. FUNERAL DIRECTOR <b>John E. Rupp</b> ADDRESS <b>St. Joseph, Mo</b>		25. DATE RECD. BY LOCAL REG. <b>May 4, 1960</b>	26. REGISTRAR'S SIGNATURE <b>Mrs. Clark Goodell</b>

DOCUMENT

C.S. Grant, M.D. MEDICAL CERTIFICATION

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

~~body~~ \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*John E. Rupp*

Licensed Embalmer No. 3986

P. O. Address St. Joseph

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.