

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**-60-014331**

FILED VS. APR 18 1960

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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>Kansas</b> b. COUNTY <b>Doniphan</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>	Length of stay in 1b <b>50 Years</b>	c. CITY OR TOWN <b>Elwood</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>309 1/2 West Mo. Ave.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1011 Atlantic St.</b>
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Irving</b> Middle <b>Bert</b> Last <b>Whitten</b>			4. DATE OF DEATH Month <b>April</b> Day <b>8</b> Year <b>1960</b>		
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</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>March 17, 1893</b>	9. AGE (last birthday) <b>67</b>	IF UNDER 1 YEAR Months <b>67</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HR Hours <b>0</b> Min. <b>0</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Butcher (ret.)</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Meat Packing</b>	11. BIRTHPLACE (City and state or country) <b>Lebanon, Missouri</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>John Whitten</b>	13b. MOTHER'S MAIDEN NAME <b>Sally Collins</b>	14. NAME OF HUSBAND OR WIFE <b>Gladys L. Whitten</b>
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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) <b>Yes WW I</b>	16. SOCIAL SECURITY NO. <b>487-05-0987</b>	17. INFORMANT <b>Mrs Bertha M. Chambers, Elwood, Kan.</b>
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Natural Causes - Unattended Death</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Investigated by City Health Officer.</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)	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
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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 <b>2:00</b> a.m. <b>0</b> p.m. <b>0</b>	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 <b>St. Joseph, Mo</b>	COUNTY	STATE
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21. I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_.  
Death occurred at **2:00 p.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Robert W. Keener M.D.</b>	22b. ADDRESS <b>St. Joseph, Mo</b>	22c. DATE SIGNED <b>4-12-60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>April 11, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ashland Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Joseph, Missouri</b>
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24. FUNERAL DIRECTOR <b>Wm. H. Alexander</b>	ADDRESS <b>St. Joseph, Mo</b>	25. DATE RECD. BY LOCAL REG. <b>April 13, 1960</b>	26. REGISTRAR'S SIGNATURE <b>Wm. Clark Hodell</b>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

R.W. Keener, M.D.

STATEMENT BY LICENSED EMBALMER

0961 6 T

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 Wm. H. Alexander

Licensed Embalmer No. 4450

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.