

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-022346

FILED VS JUL 11 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 lb Life		c. CITY OR TOWN Gower		Inside Limits Yes ☐ No ☒	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph's Hospital		Inside Limits Yes ☒ No ☐		d. STREET ADDRESS (If outside, give location) RFD #2		Reside on Farm Yes ☒ No ☐	
3. NAME OF DECEASED (Type or print) First Middle Last MARGUERITE DUNBAR ALLGAIER				4. DATE OF DEATH Month Day Year July 1 1960			
5. SEX Female		6. COLOR OR RACE White		7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐		8. DATE OF BIRTH 8-12-1899	
9. AGE (last birthday) 60		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) House-Wife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (City and state or country) Frazier, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME John Dunbar		13b. MOTHER'S MAIDEN NAME Cordelia Kelly		14. NAME OF HUSBAND OR WIFE Michael S. Allgaier			
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.		17. INFORMANT Michael S. Allgaier RR #2 Gower, 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) <u>Coronary occlusion agent</u> DUE TO (b) <u>Coronary Heart Disease agent</u> DUE TO (c) <u>5 yr.</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>4 da</u>	
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. ☐ Yes ☐ No ☐ Unknown	
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒		20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐		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 ☐ NOT WHILE AT WORK ☐		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 <u>12-12-52</u> to <u>7-1-60</u> and last saw her alive on <u>7-1-60</u> Death occurred at <u>12:15 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.		21a. SIGNATURE (Degree or title) <u>Wm B Rootm</u>		21b. ADDRESS <u>316 1/2 10th St Joseph Mo</u>		21c. DATE SIGNED <u>7-3-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE July 4, 1960		22c. NAME OF CEMETERY OR CREMATORY St. Joseph's Cemetery		22d. LOCATION (City, town, or county) Easton, Mo.	
23. FUNERAL DIRECTOR H.O. Sidenfaden & Son		ADDRESS St Joseph, Mo.		24. DATE RECD. BY LOCAL REG. July 2, 1960		25. REGISTRAR'S SIGNATURE Mrs. Clark Hardell	

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Robert H. Zapp

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 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.