

FEDERAL BUREAU OF INVESTIGATION
 U.S. DEPARTMENT OF JUSTICE
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FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-025916

FILED VS JUL 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 lb 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 D.O.A. T.B.K. Clinic <i>902 Edmond</i>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 418 S. 20th St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) MILTON KENNARD				4. DATE OF DEATH Month July Day 10 Year 1960					
5. SEX male	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 11/13/1895	9. AGE (last birthday) 64	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) Teller			10b. KIND OF BUSINESS OR INDUSTRY Bank		11. BIRTHPLACE (City and state or country) St. Joseph, Mo.		12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME Robert Kennard			13b. MOTHER'S MAIDEN NAME Christena Howard			14. NAME OF HUSBAND OR WIFE Alta			
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. 497-12-2034		17. INFORMANT Address Mrs. Alta Kennard, 418 S. 20th, St. Joseph, 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) Unattended Death - natural Causes Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Investigated by City Health Dept. 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 _____ a.m. _____ p.m. 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 _____ to _____ and last saw him alive on _____ Death occurred at 1:30 a. _____ m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <i>R.W. Kieber, M.D.</i>				22b. ADDRESS St Joseph Mo			22c. DATE SIGNED 7-12-60		
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 7/12/1960	23c. NAME OF CEMETERY OR CREMATORY Mt. Mora Cemetery		23d. LOCATION (City, town, or county) (State) St. Joseph Missouri				
24. FUNERAL DIRECTOR Heaton-Bowman,			ADDRESS St. Joseph, Mo.		25. DATE REC'D. BY LOCAL REG. July 14, 1960		26. REGISTRAR'S SIGNATURE <i>Wm. Clark Goodell</i>		

DOCUMENT

BY AFFIDAVIT OF MEDICAL CERTIFICATION
R.W. Kieber, M.D.

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 J. Spaulding

Licensed Embalmer No. 4535

P. O. Address St Joseph St

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co
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.