

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-032474

FILED VS AUG 24 1960

318

1003

8024

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

<b>1. PLACE OF DEATH</b> a. COUNTY <u>St Louis</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u> Length of stay in 1b <u>5 hrs.</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Deaconess Hosp.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Franklin</u> c. CITY OR TOWN <u>Pacific RFD #2</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>5 mi sw of Pacific</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Joseph</u> Middle <u>Victor</u> Last <u>Kober</u>			<b>4. DATE OF DEATH</b> Month <u>Aug</u> Day <u>13</u> Year <u>1960</u>				
<b>5. SEX</b> <u>m</u>	<b>6. COLOR OR RACE</b> <u>wh</u>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>June 18, 1899</u>	<b>9. AGE (last birthday)</b> <u>61</u>	<b>IF UNDER 1 YEAR</b> Months _____ Days _____ <b>IF UNDER 24 HR</b> Hours _____ Min. _____		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>farmer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>-</u>	<b>11. BIRTHPLACE</b> (City and state or country) <u>Pacific mo</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.</u>		
<b>13a. FATHER'S NAME</b> <u>Otto Kober Sr</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>Elizabeth Nicholson</u>		<b>14. NAME OF HUSBAND OR WIFE</b> <u>-</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>490-28-6290</u>	<b>17. INFORMANT</b> <u>Paul Kober</u> Address <u>Pacific mo.</u>				
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>massive cerebral hemorrhage - l. side</u> DUE TO (b) <u>Hypertensive heart disease</u> DUE TO (c) <u>Passive congestion of lungs - (severe)</u> (Specify, if any, conditions, if any, that gave rise to above cause (a), stating the underlying cause last.)					INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>443x</u>			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				
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)					
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____							
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b>		<b>COUNTY</b>		
<b>21. I attended the deceased from _____ to _____ and last saw her/him alive on _____</b> Death occurred at <u>8 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> <u>J. Kober</u> (Degree or title) <u>mo.</u>		<b>22b. ADDRESS</b> <u>Pacific mo.</u>		<b>22c. DATE SIGNED</b> <u>8/24/60</u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)	<b>23b. DATE</b> <u>Aug 16 '60</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Oak Ridge</u>	<b>23d. LOCATION</b> (City, town, or county) <u>Catawissa mo.</u> (State)				
<b>24. FUNERAL DIRECTOR</b> <u>Mrs. John P. Shieles</u> ADDRESS		<b>25. DATE RECD. BY LOCAL REG.</b> <u>AUG 15 1960</u>	<b>26. REGISTRAR'S SIGNATURE</b> <u>Loan Smith, M.D.</u>				

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 Ralph Altman

Licensed Embalmer No. 4808

P. O. Address Union, Mo

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.