

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-033123

FILED VS. AUG 26 1960

318

1003

8195

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Kansas</u> b. COUNTY <u>Crawford</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST LOUIS</u>		Length of stay in 1b <u>7 DAYS</u>		c. CITY OR TOWN <u>GIRARD</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>FRISCO HOSPITAL</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>RT#3</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle _____ Last <u>ZIBERT</u>				4. DATE OF DEATH Month <u>AUGUST</u> Day <u>16</u> Year <u>1960</u>				
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>10/6/1898</u>	9. AGE (last birthday) <u>61</u>	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) <u>RETIRED</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>RAILROADER</u>		11. BIRTHPLACE (City and state or country) <u>Yugoslavia</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>ANTON Zibert</u>			13b. MOTHER'S MAIDEN NAME <u>Maria KLOPPIC</u>			14. NAME OF HUSBAND OR WIFE <u>ANTONIA</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>Nil.</u>		17. INFORMANT Address <u>Mrs. Antonia Zibert, Girard, Kansas.</u>			
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>ANURIA</u>							INTERVAL BETWEEN ONSET AND DEATH <u>7 DAYS</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b) _____				DUE TO (c) <u>151X</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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 <u>AUGUST 9TH 1960</u> to <u>AUGUST 16 1960</u> and last saw him alive on <u>AUG-16-60</u> Death occurred at <u>4:10 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>[Signature]</u> (Degree or title)				22b. ADDRESS <u>FRISCO HOSPITAL ST LOUIS MISSOURI</u>			22c. DATE SIGNED <u>8/16/60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>8/17/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Garden of Memories</u>		23d. LOCATION (City, town, or county) (State) <u>Pittsburg, Kansas</u>			
24. FUNERAL DIRECTOR <u>Albert H. Hoppe, Inc., 4700 Washington Blvd.,</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>AUG 19 1960</u>		26. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</u>		

Medical Certification by Affidavit of _____
 Registrar's Signature _____
 Registrar's Title _____

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 Hervey Kahle

Licensed Embalmer No. 4596

P. O. Address St Louis, 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.