

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. SEP 19 1960

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-60-033934

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 1b 20 years | | 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 Arnold Nursing Home 701 S. 11th | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 2329 S. 16th St. | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First MATILDA Middle ALICIA Last RENNISON | | | | 4. DATE OF DEATH Month September Day 8 Year 1960 | | | | |
| 5. SEX female | 6. COLOR OR RACE white | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 2/12/1866 | 9. AGE (last birthday) 94 | 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) housewife | | | 10b. KIND OF BUSINESS OR INDUSTRY own home | 11. BIRTHPLACE (City and state or country) London, England | | 12. CITIZEN OF WHAT COUNTRY USA | | |
| 13a. FATHER'S NAME unknown | | | 13b. MOTHER'S MAIDEN NAME unknown | | 14. NAME OF HUSBAND OR WIFE C. S. Rennison | | | |
| 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. none | 17. INFORMANT A. M. Rennison, 1329 Francis, St. Joseph, Mo. Address _____ | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident (Repeated) DUE TO (b) Old Atherosclerosis Gen. DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 Days yes | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I. (a) Previous C.V.A. - Similarity - | | | | | 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 12-16-55 to 9-8-60 and last saw ^{her} alive on 9-8-60 Death occurred at 12:15 p. m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE Robert W. Kieber, M.D. | | | | 22b. ADDRESS St. Joseph, Mo | | 22c. DATE SIGNED 9-10-60 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) burial | 23b. DATE 9/10/1960 | 23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery | | 23d. LOCATION (City, town, or county) (State) St. Joseph Missouri | | | | |
| 24. FUNERAL DIRECTOR Heston - Bowman, St. Joseph, Mo | | | 25. DATE RECD. BY LOCAL REG. Sept. 14, 1960 | | 26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell | | | |

DOCUMENT

R. W. Kieber, M.D. 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 _____

Eugene Wood

Licensed Embalmer No. *3804*

P. O. Address *314 1/2 10th St*

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.