

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS OCT 17 1960 042

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60-033938

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 50 Yrs		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 INSTITUTE Rose Leon Nursing Home 624 Prospect Ave.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1904 Main St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First MIDDLE Last ELIZABETH R. RUSH				4. DATE OF DEATH Month Day Year October 11, 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 7-6-1893	9. AGE (last birthday) 67	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (City and state or country) Conception, Mo.		12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME James P. Smith			13b. MOTHER'S MAIDEN NAME Katherine Burke			14. NAME OF HUSBAND OR WIFE Harry			
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 Richard L. Rush			Address 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) <u>cerebral vascular accident</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>		
DUE TO (b) <u>arteriosclerotic cardiovascular disease</u>							2 1/2 mo		
DUE TO (c) _____									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Brain intercranial hemorrhage 8-1-60</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		
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 <u>1-23-60</u> to <u>10-11-60</u> and last saw her <u>alive</u> on <u>9-20-60</u> Death occurred at <u>4:05 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>R.L. Maginn MD</u>				22b. ADDRESS <u>St. Joseph, Mo</u>			22c. DATE SIGNED <u>10-12-60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Oct. 14, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>St. Joseph, Mo.</u>					
24. FUNERAL DIRECTOR <u>H.O. Siefert & Son R.F.</u>			ADDRESS <u>St Joseph Mo</u>		25. DATE RECD. BY LOCAL REG. <u>Oct. 13, 1960</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. Clark Goodell</u>		

DOCUMENT

BY AFFIDAVIT OF MEDICAL CERTIFICATION R.L. Maginn MD

DEC 27 1980

Dr Maginn

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 L. Gaph*

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 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.