

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-037584

FILED VS OCT 3 1 1960

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 1114

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Buchanan				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Buchanan									
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in lb 10Yrs		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 Missouri Methodist			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 2511 St. Joseph Ave.,		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First JAMES Middle PETER Last WESCOTT				4. DATE OF DEATH Month Oct. Day 21 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 Oct. 24 1881		9. AGE (last birthday) 78		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) Retired Farmer				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (City and state or country) Bynumville Mo.		12. CITIZEN OF WHAT COUNTRY U.S.			
13a. FATHER'S NAME Robert Wescott				13b. MOTHER'S MAIDEN NAME Nancy Smith				14. NAME OF HUSBAND OR WIFE Pearl Wescott					
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 Address Pearl Wescott, 2511 St. Joseph Ave 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) Cerebral Vascular Accident Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Old Arteriosclerosis Hem DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 72 mos + Yrs.					
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 10-21-60 to 10-21-60 and last saw him alive on 10-21-60 Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE Robert W. Kieber, M.D. (Designation or title)						22b. ADDRESS St. Joseph, Mo			22c. DATE SIGNED 10-22-60				
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 10-22-60		23c. NAME OF CEMETERY OR CREMATORY Riggs				23d. LOCATION (City, town, or county) (State) Weatherby Mo (Rural)					
24. FUNERAL DIRECTOR Pilcher Funeral Home Maysville Mo ADDRESS				25. DATE RECD. BY LOCAL REG. Oct. 22, 1960		26. REGISTRAR'S SIGNATURE Mrs. Charles Sandell							

DOCUMENT

MEDICAL CERTIFICATION
R.W. Kieber, M.D.

BY AFFIDAVIT OF

VS FEB 24 1960

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


C. L. Filcher

Licensed Embalmer No. 3960

P. O. Address Maysville 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.