

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

LED VS NOV 7 1960

-60-039175

Registration District No. 201 Primary Registration District No. 4374 Registrar's No. 248

STATE FILE NUMBER

DED

|  |  |  |  |   |  |  |   |         |  |
|--|--|--|--|---|--|--|---|---------|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>NODAWAY</b>  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MO.</b> b. COUNTY <b>NODAWAY</b> |  |  |   |         |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>CLYDE</b>   |  | Length of stay in 1b <b>4 yrs.</b>   |  | c. CITY OR TOWN <b>CLYDE</b>  |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |   |         |  |
| c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>BENEDICTINE CONVENT</b>   |  |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |   | d. STREET ADDRESS (if outside, give location) <b>BENEDICTINE CONVENT</b>   |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |         |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last <b>SISTER MARY COLETTA RAST</b>  |  |  |  | 4. DATE OF DEATH Month Day Year <b>Oct. 26, 1960</b>  |  |  |   |         |  |
| 5. SEX <b>FEMALE</b>   | 6. COLOR OR RACE <b>WHT</b>            | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>2-21-76</b>   | 9. AGE (last birthday) <b>84</b>   | IF UNDER 1 YEAR<br>Months Days   | IF UNDER 24 HR<br>Hours Min.  |         |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RELIGIOUS</b>   |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>RELIGIOUS</b>                                   |   | 11. BIRTHPLACE (City and state or country) <b>SWITZERLAND</b>  |  | 12. CITIZEN OF WHAT COUNTRY <b>USA</b>  |         |  |
| 13a. FATHER'S NAME <b>JOSEPH RAST</b>  |  |  | 13b. MOTHER'S MAIDEN NAME <b>VERENA FEER</b>   |   |  | 14. NAME OF HUSBAND OR WIFE  |   |         |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>   |  |  | 16. SOCIAL SECURITY NO. <b>---</b>   |   | 17. INFORMANT <b>BENEDICTINE CONVENT, CLYDE, MO.</b>   |  |   | Address |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b>   |  |  |  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH  |         |  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <b>Coronary atherosclerosis</b>   |  |  |  |   |  |  | 10yrs   |         |  |
| DUE TO (c) <b>Thrombosis</b>   |  |  |  |   |  |  |   |         |  |
| 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.<br><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 checked="" 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 <b>Oct 25, 1960</b> to <b>Oct 26, 1960</b> and last saw her <b>Oct 25, 1960</b> alive on <b>Oct 25, 1960</b><br>Death occurred at <b>4:25 a.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated. |  |  |  |   |  |  |   |         |  |
| 22a. SIGNATURE <b>[Signature]</b> (Degree or title)  |  |  |  | 22b. ADDRESS <b>Waverly, Mo</b>   |  |  | 22c. DATE SIGNED <b>10/29/60</b>  |         |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  | 23b. DATE                              | 23c. NAME OF CEMETERY OR CREMATORIAL   |  |   | 23d. LOCATION (City, town, county) (State)   |  |   |         |  |
| <b>BURIAL</b>  | <b>OCT 29, 1960</b>                    | <b>MT. CALVARY</b>   |  |   | <b>CLYDE, MO.</b>  |  |   |         |  |
| 24. FUNERAL DIRECTOR ADDRESS <b>Johnson Funeral Homes, Stamberry, Mo</b>   |  |  |  | 25. DATE RECD. BY LOCAL REG. <b>10-29-60</b>  |  | 26. REGISTRAR'S SIGNATURE <b>Bess Holt</b>   |   |         |  |

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 Boas Evangelista

Licensed Embalmer No. 4948

P. O. Address Stauber

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.