

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-041100

FILED VS NOV 28 1960

042

Primary Registration District No. 1000

Registrar's No. 1205

STATE FILE NUMBER

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1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Kansas COUNTY Leavenworth	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph,	Length of stay in 1b 1 week	c. CITY OR TOWN Leavenworth	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph Hospital		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 521 So 7th
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Clarence Middle L Last Fueston	4. DATE OF DEATH Month Nov. Day 16, Year 1960
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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 Feb. 27, 1907	9. AGE (last birthday) 53	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse Aide	10b. KIND OF BUSINESS OR INDUSTRY Hospital	11. BIRTHPLACE (City and state or country) Clinton Mo	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Unk	13b. MOTHER'S MAIDEN NAME Unk	14. NAME OF HUSBAND OR WIFE Erma Fueston
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW# II	16. SOCIAL SECURITY NO. 491-10-7428	17. INFORMANT Erma Fueston Leavenworth Kansas
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Acute cardiac failure		8 hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Pulmonary emboli	12 hours
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Carcinoma of upper lobe, right lung with mediastinal metastasis.	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input 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.)
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20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Month, Day, Year
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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 St. Joseph, Mo.	COUNTY Kansas	STATE
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21. I attended the deceased from **Oct. 10, 1960** to **Nov. 16, 1960** and last saw **him** alive on **Nov. 15, 1960**
Death occurred at **4:45 a.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) J.R.M. Daniel M.D.	22b. ADDRESS 902 Edmond St. St. Joseph, Mo.	22c. DATE SIGNED 11-18-60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 11/16/60	23c. NAME OF CEMETERY OR CREMATORY National Cemetery	23d. LOCATION (City, town, or county) (State) Ft Leavenworth Kansas
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24. FUNERAL DIRECTOR John E. [Signature]	ADDRESS St. Joseph, Mo	25. DATE RECD. BY LOCAL REG. Nov. 21, 1960	26. REGISTRAR'S SIGNATURE Wm. Clark Gardell
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NOV 28 1961

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

~~one~~ _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed John E. Ryan

Licensed Embalmer No. 398

P. O. Address St. Joe

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