

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS NOV 21 1960

-60-041108

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 1185 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Clinton</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St Joseph</b>		c. CITY OR TOWN <b>Gower</b>	
Length of stay in lb <b>10 da.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Mo. Methodist Hosp.</b>		d. STREET ADDRESS (If outside, give location) <b>S. 3<sup>rd</sup> St.</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Lena</b> Middle <b>(N)</b> Last <b>Helberg</b>			4. DATE OF DEATH Month <b>Nov.</b> Day <b>12</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 25, 1884</b>	9. AGE (last birthday) <b>75</b>	IF UNDER 1 YEAR IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Homemaker</b>		11. BIRTHPLACE (City and state or country) <b>Austria-Hungary</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>

13a. FATHER'S NAME <b>M. Focht</b>		13b. MOTHER'S MAIDEN NAME <b>Elizabeth Frische</b>		14. NAME OF HUSBAND OR WIFE <b>John Helberg</b>	
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>498-42-1576</b>		17. INFORMANT <b>Mack J Helberg</b> Address	

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) <b>Coronary Thrombosis</b>		<b>4 hours</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Coronary arteriosclerosis and atherosclerosis</b>	<b>5 years</b>	
	DUE TO (c) <b>Arteriosclerosis, Heart Dis-</b>	<b>5 yrs</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. <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 **April 16 58** to **Nov. 12, 1960** and last saw her alive on **Nov. 12, 1960**  
 Death occurred at **4:00 P** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>John P. Mabrey M.D.</b>		22b. ADDRESS <b>Plattsburg, Mo.</b>		22c. DATE SIGNED <b>11-16-60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Nov. 15, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Green Lawn</b>	23d. LOCATION (City, town, or county) (State) <b>Plattsburg Mo.</b>	
24. FUNERAL DIRECTOR <b>Clarence E. Zipes - Gower Mo</b> ADDRESS		25. DATE RECD. BY LOCAL REG. <b>Nov. 18, 1960</b>	26. REGISTRAR'S SIGNATURE <b>Mrs. Clark Stodell</b>	

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF **John P. Mabrey, Medical Certification**

**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 Donald W. Hankes

Licensed Embalmer No. 4528

P. O. Address Smithville, 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.