

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-041144

FILED VS NOV 28 1960

042 Primary Registration District No. 1000 Registrar's No. 1195

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <i>Buchanan</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Buchanan</i>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Joseph</i>		Length of stay in 1b <i>Life</i>		c. CITY OR TOWN <i>St. Joseph</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Mo. Methodist Hospital</i>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <i>3328 Lafayette St.</i>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <i>Lyle</i> Middle <i>E</i> Last <i>Pasternak</i>				4. DATE OF DEATH Month <i>November</i> Day <i>15</i> Year <i>1960</i>									
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <i>Aug. 10, 1915</i>		9. AGE (last birthday) <i>45</i>		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) <i>Toll Department</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>So. West. Bell Telephone</i>			11. BIRTHPLACE (City and state or country) <i>St. Joseph, Mo.</i>			12. CITIZEN OF WHAT COUNTRY <i>USA</i>				
13a. FATHER'S NAME <i>Ed Pasternak</i>			13b. MOTHER'S MAIDEN NAME <i>Mary Engelman</i>			14. NAME OF HUSBAND OR WIFE <i>Josephine Pasternak</i>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <i>Yes W.W. 2</i>			16. SOCIAL SECURITY NO. <i>497-09-8127</i>			17. INFORMANT Address <i>Mrs. Lyle E. Pasternak 3328 Lafayette St.</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i>										INTERVAL BETWEEN ONSET AND DEATH <i>Nov. 6. 60</i>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)													
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 Month, Day, Year a.m. p.m.													
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 Death occurred at		<i>4-28-55</i> to <i>11-15-60</i>			and last saw him alive on <i>11-15-60</i>								
21. I attended the deceased from <i>11:15 p</i> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <i>Robert W. Kieber, M.D.</i>					22b. ADDRESS <i>St. Joseph, Mo</i>					22c. DATE SIGNED <i>11-16-60</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Nov. 17, 1960</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Memorial Park Cemetery</i>			23d. LOCATION (City, town, or county) (State) <i>St. Joseph, Mo.</i>						
24. FUNERAL DIRECTOR <i>Clark Funeral Home St. Joseph, Mo.</i>				25. DATE RECD. BY LOCAL REG. <i>Nov. 18, 1960</i>		26. REGISTRAR'S SIGNATURE <i>Mrs. Clark Handell</i>							

DOCUMENT

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

BY AFFIDAVIT OF

NOV 29 1960

FEB 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 _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Emilia Clark

Licensed Embalmer No. 4238

P. O. Address St. George

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.