

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-045180
STATE FILE NUMBER

FILED VS DEC 19 1960 042

Registration District No. _____ Primary Registration District No. 1000 Registrar's No. 1293

| | | | | | | | |
|---|--|--|---|--|---|--|----------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | | | |
| a. COUNTY Buchanan | | b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph | | Length of stay in lb 161 Days | | c. CITY OR TOWN St. Joseph | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph State Hospital | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 3106 Seneca Street | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | | | | 4. DATE OF DEATH | | | |
| First JOHN | | Middle HENRY | | Last DOLT | | Month Day Year December 10 1960 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 11-25-1868 | 9. AGE (last birthday) 92 | IF UNDER 1 YEAR | | IF UNDER 24 HR |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miller | | 10b. KIND OF BUSINESS OR INDUSTRY Milling | | 11. BIRTHPLACE (City and state or country) Brookfield, Missouri | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13a. FATHER'S NAME Andrew Dolt | | | 13b. MOTHER'S MAIDEN NAME Unknown | | 14. NAME OF HUSBAND OR WIFE Agnes Dolt | | |
| 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. 488-14-3569 | | 17. INFORMANT Mrs. Anna Dabler St. Joseph, Missouri | | | |
| 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) Brain Hemorrhage | | | | | | June 10, 1960 | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) General Arteriosclerosis | | | | | | 10 Years | |
| 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 | | | | | | | |
| 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 12-10-1960 to 12-10-1960 and last saw her/him alive on 12-10-1960 | | | | | | | |
| Death occurred at 3:10 P.m. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Degree or title) C.E. Gossins M.D. | | | | 22b. ADDRESS St. Joseph State Hospital St. Joseph, Missouri | | 22c. DATE SIGNED 12-10-1960 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 12-13-1960 | 23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery | | 23d. LOCATION (City, town, or county) St. Joseph Missouri | | | |
| 24. FUNERAL DIRECTOR H.O. Sidenfaden & Son St Joseph, Mo | | | 25. DATE RECD. BY LOCAL REG. Dec 15, 1960 | | 26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell | | |

DOCUMENT

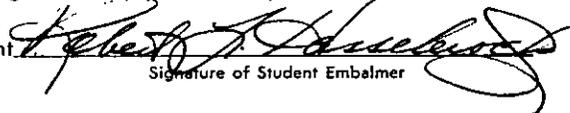
C.E. Gossins M.D. MEDICAL CERTIFICATION

BY AFFIDAVIT OF

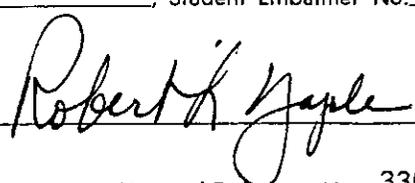
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by Robert L. Hassebroek, Student Embalmer No. 617

working under my personal supervision.

Student 

Signature of Student Embalmer

Signed 

Licensed Embalmer No. 3308

P. O. Address St. Joseph, Miss

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.