

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

042

1000

Registrar's No.

679

-61-024155

STATE FILE NUMBER

Registration District No.

Primary Registration District No.

AMENDED

**FILED JUL 17 1961**

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|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Buchanan</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b> |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph, Missouri</b>                  |  | Length of stay in 1b <b>2 Years</b>   | c. CITY OR TOWN <b>St. Joseph, Missouri</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>Missouri Methodist Hospital</b> |  | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>   | d. STREET ADDRESS (If outside, give location) <b>1501 Douglas St.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|---|--|--|---|--|--|
| 3. NAME OF DECEASED (Type or print)<br>First <b>LUVERNA</b> Middle <b>E.</b> Last <b>MADINGER</b> |  |  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>7</b> Year <b>1961</b> |  |  |
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|                      |                               |  |  |                                  |   |  |
|----------------------|-------------------------------|--|--|----------------------------------|---|--|
| 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>Mo. unknown 1884</b> | 9. AGE (last birthday) <b>77</b> | IF UNDER 1 YEAR<br>Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> | IF UNDER 24 HR<br>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) <b>Housewife</b> | 10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b> | 11. BIRTHPLACE (City and state or country) <b>Notknown</b> | 12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b> |
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|                                   |  |   |
|-----------------------------------|--|---|
| 13a. FATHER'S NAME <b>Unknown</b> | 13b. MOTHER'S MAIDEN NAME <b>Unknown</b> | 14. NAME OF HUSBAND OR WIFE <b>C.E. Madinger</b><br>Address |
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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) <b>No</b> | 16. SOCIAL SECURITY NO. <b>Unknown</b> | 17. INFORMANT <b>Minnie Knapp, St. Joseph, Missouri</b><br>Address |
|--|--|--|

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| 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 Cerebral Hemorrhage</b> |  | INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> |
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Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) \_\_\_\_\_  
DUE TO (c) \_\_\_\_\_

|   |  |
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| 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 |
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| 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.) |
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| 20c. TIME OF INJURY<br>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 COUNTY STATE |
|--|--|---|

21. I attended the deceased from **6/9/61** to **7/7/61** and last saw **her** alive on **7/7/61**  
Death occurred at **9:35 PM** on the date stated above, and to the best of my knowledge, from the causes stated.

|  |  |                                 |
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| 22a. SIGNATURE (Deceased or Informant) <b>Donald F. Sklenar M.D.</b> | 22b. ADDRESS <b>Social Welfare Board 10th &amp; Olive, St. Joseph, Mo.</b> | 22c. DATE SIGNED <b>7/10/61</b> |
|--|--|---------------------------------|

|  |                                |  |  |
|--|--------------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b> | 23b. DATE <b>July 11, 1961</b> | 23c. NAME OF CEMETERY OR CREMATORY <b>Belmont Cemetery</b> | 23d. LOCATION (City, town, or county) (State) <b>Wathena, Kansas</b> |
|--|--------------------------------|--|--|

|   |   |   |
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| 24. FUNERAL DIRECTOR <b>Meierhoffer-Fleeman Inc. St. Joseph, Missouri</b> | 25. DATE RECD. BY LOCAL REG. <b>July 12, 1961</b> | 26. REGISTRAR'S SIGNATURE <b>Mrs. Clara Goodell</b> |
|---|---|---|

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

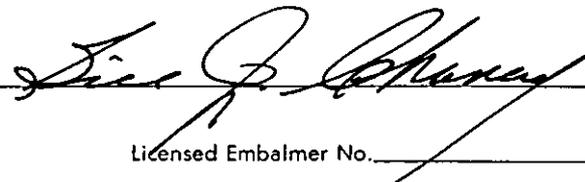
DOCUMENT

BY AFFIDAVIT OF CERTIFICATION **D.F. Sklenar M.D.**

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed  \_\_\_\_\_  
Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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.