

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-031960

AMENDED Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 964 STATE FILE NUMBER

FILED OCT 2 1961

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>		Length of stay in 1b <u>40 yrs</u>	c. CITY OR TOWN <u>St. Joseph</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>921 Ridenbaugh</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1309 No 11 St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>MABELL CLEO KUBIC</u>			4. DATE OF DEATH Month Day Year <u>Sept. 21 1961</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 21 1898</u>	9. AGE (last birthday) <u>63</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>Fillmore Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>U S A</u>
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13a. FATHER'S NAME <u>ALFRED DANIELS</u>	13b. MOTHER'S MAIDEN NAME <u>HATTIE SPARKS</u>	14. NAME OF HUSBAND OR WIFE <u>Richard Kubic (deceased)</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>Mrs Francis Spalding St. Joseph Mo.</u>
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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: IMMEDIATE CAUSE (a) <u>Cerebral-Vascular Accident</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7-7-61</u>  <u>10 years</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Hypertension. Long-standing Cardio-</u>	
	DUE TO (c) <u>Vascular Disease.</u>	

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"/> N. <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 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
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21. I attended the deceased from <u>2-25-46</u> to <u>9-21-61</u> and last saw her <u>alive</u> on <u>9-21-61</u> Death occurred at <u>12:20 P/</u> on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <u>Lieut. B. Kelley M.D.</u>	22b. ADDRESS <u>Savannah, Missouri</u>	22c. DATE SIGNED <u>9-25-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <input checked="" type="checkbox"/> Burial	23b. DATE <u>Sept 23 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Savannah Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Savannah Missouri</u>
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24. FUNERAL DIRECTOR ADDRESS <u>St. Joseph Home St. Joseph Mo</u>	25. DATE RECD. BY LOCAL REG. <u>Sept. 27, 1961</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Clark Standell</u>
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DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF G. B. Kelley, M.D. 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 me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed Charles E. Bennett

Licensed Embalmer No. 4677

P. O. Address St Joseph Mo

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.