

MOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-040229

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

042

1000

1249

STATE FILE NUMBER

AMENDED

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

FILED DEC 11 1961

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		a. STATE Iowa		b. COUNTY Grundy	
Length of stay in 1b 3 weeks		c. CITY OR TOWN Conrad		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) Conrad	
c. FULL NAME OF (If NOT in hospital, give location), HOSPITAL OR Hillside Nursing Home INSTITUTION 718 No. 7th St.		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)				4. DATE OF DEATH			
First EDITH		Middle CORA		Last ROCKHILL		Month Day Year December 3 1961	
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2/8/1876	9. AGE (last birthday) 85	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (City and state or country) Marshalltown Iowa		12. CITIZEN OF WHAT COUNTRY U S A	
13a. FATHER'S NAME Fred Naumann			13b. MOTHER'S MAIDEN NAME Amelia Miller		14. NAME OF HUSBAND OR WIFE Mr. J. D. Rockhill		
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. None		17. INFORMANT Mrs. W.M. McGee			
				Address 3115 Seneca St. St. Joseph, Mo.			
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) arteriosclerotic heart disease with congestive failure							
DUE TO (b) Nephrosclerosis with uremia							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Fractured hip, right 7x humerus right							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 Jan 19 56 to Dec 3, 1961 and last saw her alive on Nov 30, 1961				Death occurred at 2:40P m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) M. H. Christ, M.D.				22b. ADDRESS 1106 King Hill Ave St Joseph Mo		22c. DATE SIGNED 12-4-61	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 12/4/61	23c. NAME OF CEMETERY OR CREMATORY Conrad Cemetery		23d. LOCATION (City, town, or county) Conrad		23e. STATE Iowa	
24. FUNERAL DIRECTOR Stamps Funeral Home			ADDRESS St. Joseph, Mo.		25. DATE RECD. BY LOCAL REG. Dec. 6, 1961		26. REGISTRAR'S SIGNATURE Mrs. Clark Goodall

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

M. H. Christ, M.D.

BY AFFIDAVIT OF

DEC 19 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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Paul F. Clark

Licensed Embalmer No. 5024

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.