

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-043681

AMENDED

Filed ⁰⁴² DEC 18 1961

Primary Registration District No. 1000 Registrar's No. 1264

STATE FILE NUMBER

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF S.E. Melumey, M.D. MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Buchanan				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan													
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in 1b Life		c. CITY OR TOWN St. Joseph		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>											
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION 27th & Mulberry Sts.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 3305 Iroquois		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print) First JOHN Middle JOSEPH Last KNIOLA				4. DATE OF DEATH Month December Day 6, Year 1961													
5. SEX Male		6. COLOR OR RACE White		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 10-24-1945		9. AGE (last birthday) 16		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student				10b. KIND OF BUSINESS OR INDUSTRY School		11. BIRTHPLACE (City and state or country) St. Joseph, Mo.		12. CITIZEN OF WHAT COUNTRY USA									
13a. FATHER'S NAME John Kniola				13b. MOTHER'S MAIDEN NAME Lylia Showalter				14. NAME OF HUSBAND OR WIFE None									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No						17. INFORMANT Address John Kniola St. Joseph, Mo.											
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>Traumatic shock + hemorrhage</i> <i>Basilar skull fracture + fractured</i> <i>Cervical vertebrae - crushed + vertebral fracture</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>same as above</i> DUE TO (c) <i>2 car auto accident</i>										INTERVAL BETWEEN ONSET AND DEATH <i>at once</i> <i>at once</i> <i>at once</i>							
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 checked="" 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.) <i>2 car collision</i>													
20c. TIME OF INJURY Hour <i>3:03</i> p.m. Month, Day, Year <i>Dec 6 61</i>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> <i>Viewed</i>								20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>City street</i>		20f. CITY, TOWN, OR LOCATION <i>St Joseph</i>		COUNTY <i>Buchanan</i>		STATE <i>Mo.</i>	
21. I certify the deceased from <i>received body</i> and last saw him <i>Dec 6-61</i> Death occurred at <i>3:03p</i> on the date stated above, and to the best of my knowledge, from the causes stated.																	
22. SIGNATURE <i>S.E. Melumey M.D.</i>				(Degree or title) <i>Reasoner St Joseph, Mo</i>				22b. ADDRESS <i>14 West Patrick St Joseph, Mo</i>		22c. DATE SIGNED <i>Dec 8-61</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>12-9-61</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet Cemetery</i>				23d. LOCATION (City, town, or county) <i>St. Joseph, Mo.</i>									
25. FUNERAL DIRECTOR <i>H.D. Sidenfaden & Son</i>				ADDRESS <i>St Joseph, Mo</i>		25. DATE RECD. BY LOCAL REG. <i>Dec. 8, 1961</i>		26. REGISTRAR'S SIGNATURE <i>Edw. Clark Goodell</i>									

DEC 29 1961

FEB 6 1962

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 Robert H. Yaph

Licensed Embalmer No. 3308

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.