

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-031739

STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 172

DO NOT WRITE ON THIS STUB

AMENDED

FILED SEP 5 1962

1. PLACE OF DEATH a. COUNTY <u>LIVINGSTON</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CHILLICOTHE</u> Length of stay in lb <u>1 1/2 YRS.</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>SUSAN'S NURSING HOME</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>LIVINGSTON</u> c. CITY OR TOWN <u>CHILLICOTHE</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>320 WILLIAMS ST.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
3. NAME OF DECEASED First Middle Last (Type or print) <u>ROSA ELIZABETH TIBERGHEN</u>		4. DATE OF DEATH Month Day Year <u>AUGUST 15 1962</u>					
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>10/15/1891</u>	9. AGE (last birthday) <u>70</u>	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) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (City and state or country) <u>SPRINGHILL, MO.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>GEORGE VOLK</u>			13b. MOTHER'S MAIDEN NAME <u>MARY LEONA HAYNES</u>		14. NAME OF HUSBAND OR WIFE <u>SHELBY TIBERGHEN</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) <u>NO</u> (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>MRS. WARREN KRAUSE: CHILLICOTHE, MO.</u>		
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>Pneumonia Terminal</u> DUE TO (b) <u>Arterial sclerosis severe</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>2 Jaws</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cerebral Embolism - Paralysis of R. side June 17, 60</u>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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.) <u>None</u>			
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	
21. I attended the deceased from <u>Feb. 10-59</u> to <u>Aug 15-62</u> and last saw her <u>live on Aug 12-62</u> Death occurred at <u>12:05</u> A m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Joseph Conrad M.D.</u>				22b. ADDRESS <u>Chillicothe, Mo</u>		22c. DATE SIGNED <u>Aug 28-62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>8/17/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVE CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>LIVINGSTON COUNTY, MISSOURI</u>	
24. FUNERAL DIRECTOR ADDRESS <u>NORMA N FUNERAL HOME: Chillicothe, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>Aug 28, 1962</u>		26. REGISTRAR'S SIGNATURE <u>Annalee Taylor</u>	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 1 0595
 2 0595
 3
 4 1
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 7 0
 8 2
 9 332X
 10
 11
 12 86-0
 13 1-0
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 ITEM NO.
 BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

DATE TAKEN TO DR. CONRAD

8/15/62

DATE REC'D. FROM DR. CONRAD

8/29/62

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 John D. Rodgers

Licensed Embalmer No. 4963

P. O. Address CHILLICOTHE, MISSOURI

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.