

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-033789

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

042

1000

1031

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

FILED SEP 17 1962

VS 300
Rev. 4/59

15117

25117

3

4 1

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94200

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1286-0

13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

D.E. Skelton, Medical Certification

USE BLACK INK OR TYPEWRITER RIBBON

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,		c. CITY OR TOWN St. Joseph,	
Length of stay in 1b 60 years		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Wilson Nursing Home		d. STREET ADDRESS (If outside, give location) 2607 Penn Street	
3. NAME OF DECEASED (Type or print) First MARIE Middle ANNA Last GEIGER		4. DATE OF DEATH Month September Day 10 Year 1962	
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Jan. 5, 1865
9. AGE (last birthday) 97		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) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (City and state or country) Ray County, Mo.
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME Samuel Miller	
13b. MOTHER'S MAIDEN NAME Elizabeth Krebs		14. NAME OF HUSBAND OR WIFE Fred Geiger	
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 Niece Address Mrs. Eloys Klaiber-St. Joseph, Missouri
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease			INTERVAL BETWEEN ONSET AND DEATH Unknown
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
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 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 _____ 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 6/12/61 to 9/10/62 and last saw her/him alive on 9/7/62		Death occurred at 6:15 PM m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE D.E. Skelton M.D. (Degree or title)		22b. ADDRESS SOCIAL WELFARE BOARD 10th & Olive, St. Joseph, Mo.	22c. DATE SIGNED 9/12/62
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Sept. 13, 1962	23c. NAME OF CEMETERY OR CREMATORY Rochester Cemetery	23d. LOCATION (City, town, or county) (State) Rochester, Missouri
24. FUNERAL DIRECTOR Meierhoffer-Fleeman Inc., St. Joseph, Mo.		25. DATE RECD. BY LOCAL REG. Sept. 14, 1962	26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell

Permit record 9/11/62

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 _____

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.