

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-033812

DEPARTMENT OF PUBLIC HEALTH AND WELFARE 042

1000 1095

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

<b>DECEASED OCT 1 1962</b>	
1. PLACE OF DEATH	
a. COUNTY <b>Buchanan</b>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>	a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Goroth's Nursing Home</b>	c. CITY OR TOWN <b>St. Joseph</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. STREET ADDRESS <b>180 1/2 Faraon St.</b>	d. STREET ADDRESS (If outside, give location) <b>217 North 12th</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)	
First <b>JENNIE</b>	Middle <b>MAY</b> Last <b>KREINBUEHL</b>
4. DATE OF DEATH	Month <b>September</b> Day <b>24</b> Year <b>1962</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>
7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>5-29-1883</b>
9. AGE (last birthday) <b>79</b>	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) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>
11. BIRTHPLACE (City and state or country) <b>St. Joseph, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>John G. Hill</b>	13b. MOTHER'S MAIDEN NAME <b>Not Known</b>
14. NAME OF HUSBAND OR WIFE <b>Joseph F. Kreinbuehl</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. _____
17. INFORMANT <b>J.F. Kreinbuehl</b>	Address <b>217 No. 12th City</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY:	
IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b>	INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerosis Generalized</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) <b>Arteriosclerotic Heart Disease Diabetes mellitus</b>	
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.)	
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 checked="" 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 <b>1946</b> to <b>9-24-62</b> and last saw her/him alive on <b>9-23-62</b> . Death occurred at <b>9:30 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <b>I. J. Rosenthal M.D.</b>	22b. ADDRESS <b>St Joseph Mo.</b>
22c. DATE SIGNED <b>9-26-62</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>9-27-1962</b>
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Joseph, Mo.</b>
24. FUNERAL DIRECTOR <b>H.O. Sideman &amp; Son St Joseph, Mo</b>	25. DATE RECD. BY LOCAL REG. <b>Sept. 27, 1962</b>
26. REGISTRAR'S SIGNATURE <b>Mrs. Clark Goodell</b>	

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

I. J. Rosenthal Medical Certification

VS 300  
Rev. 4/59

15117  
25117

3  
4 1  
5 1  
6  
7 0  
8 2  
9 332X  
10  
11  
12 86-0  
13 1-0

R.R.Y.

(Licensed Embalmer's Statement on Reverse Side)

Permit issued 9/27/62

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 Robert G. Gape

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.

Printed