

S. No. 2  
M-5-43  
5-17-39  
I X36871

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

20659

State File No.

Registrar's No.

FILED JUL 11 1946  
Registration District No. 146

Primary Registration District No. 3026

218

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Independence  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
1314 West Maple Street  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 12 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME JOSEPH JOHN VAN RIETTE

3. (b) If veteran, name war None

3. (c) Social Security No. 494-30-5123

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Bertha

6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased December 23, 1867  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>78</u>	<u>5</u>	<u>17</u>	hr. min.

9. Birthplace Belgium  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Miner

MOTHER FATHER

11. Industry or business

12. Name Joseph Van Riette 4

13. Birthplace Belgium  
(City, town, or county) (State or foreign country)

14. Maiden name Emerant Dubay

15. Birthplace Belgium  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Jos. Van Riette

(b) Address 1314 West Maple Street

17. (a) Burial (b) Date thereof June 13, 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mound Grove Cemetery

18. (a) Signature of funeral director Paul C. Carman

(b) Address 6113/100 Independence, Mo

19. (a) (Date received local registrar) (b) Jan 1946 (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Independence 4  
(If outside city or town limits, write "RURAL")

(d) Street No. 1314 West Maple Street 4  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 11th  
year 1946 hour 11 minute 30 P.M.

21. I hereby certify that I attended the deceased from 1/7/46  
\_\_\_\_\_, 19\_\_\_\_, to 6/11/46, 19\_\_\_\_;

that I last saw h. im. alive on June 10, 1946, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchiogenic carcinoma of apex of lung (left)

Due to \_\_\_\_\_

Duration

1 yr. (?)

Other conditions Metastasis in ribs 1 yr.  
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)

(c) Means of injury \_\_\_\_\_

23. Signature Chas. F. Grabske (M.D. or other)  
CHAS. F. GRABSKÉ, M.D.  
Address 129 N. Lexington St. Date signed 6/13/46  
Independence, Mo.

354

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**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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed..... *Dean Owens* .....

Licensed Embalmer No. *4280* .....

P. O. Address *Indep. 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 this body is not embalmed, fact should be so stated above.**