

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED SEP 22 1951

State File No.

BIRTH NO. _____ REG. DIST. NO. 146 PRIMARY REG. DIST. NO. 55-70 Registrar's No. 337

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Sibley-rural, Fort Osage twsp		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Sibley-rural-Fort Osage twsp. <u>0480</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION Route No. 1		d. STREET ADDRESS (If rural, give location) Route No. 1 <u>0</u>	

3. NAME OF DECEASED (Type or Print) Joseph I. Ahring			4. DATE OF DEATH (Month) (Day) (Year) Sept. 10, 1951		
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH April 24, 1884	9. AGE (In years last birthday) 67	IF UNDER 1 YEAR Months 4 Days 16
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Sibley, Mo. ()	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					

13a. FATHER'S NAME Leonard Jackson	13b. MOTHER'S MAIDEN NAME Sarah Glass	14. NAME OF HUSBAND OR WIFE Albert G. Ahring
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Albert G. Ahring, Sibley, Mo.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Treated for Heart		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) natural	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Fort Osage Township Jackson Mo.
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Beulah H. Queen, Coroner	23b. ADDRESS 1134 Realth Blvd	23c. DATE SIGNED 9-11-51
24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE Sept. 12, 1951	24c. NAME OF CEMETERY OR CREMATORY Buckner Hill Cemetery, Buckner, Missouri
24d. LOCATION (City, town, or county) (State) Buckner, Mo.	25a. FUNERAL DIRECTOR'S SIGNATURE James A. Coady	25b. ADDRESS Buckner, Mo.

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

480

SEP 19 RECD

OCT 3 1951

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
Student Embalmer

Signed Ralph Jones
Licensed Embalmer No. 4604

P. O. Address Buckner, 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.