

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-012439

STATE FILE NUMBER

FILED MAY 4 1959 Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 429

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		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Joseph 0117 0		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1304 Paragon St. INSTITUTION Goforth N.H.		Length of stay in lb 50 Yrs	d. STREET ADDRESS (If outside, give location) 2633 Jule St		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Nell M. Werner			4. DATE OF DEATH Month Day Year April 23, 1959		
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 August 9, 1879	9. AGE (In years last birthday) 79	F UNDER 1 YEAR Months Days IF UNDER 24 HRS. 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 At Home	11. BIRTHPLACE (City and state or country) Lebanon, Mo.		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME James Moran		13b. MOTHER'S MAIDEN NAME Teresa Donlin		14. NAME OF HUSBAND OR WIFE Chas. H.	
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 Address Mary Moran Denver, Colo.		
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>Cerebral Vascular Accident (multiple)</u> 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) <u>Terminal Pneumonia</u>					INTERVAL BETWEEN ONSET AND DEATH <u>10-12 Days</u>
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.) 331X			
20c. TIME OF INJURY Hour Month, Day, Year o.m. p.m.					
20d. INJURY OCCURRED WHILE AT <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.) 4-5-59	20f. CITY, TOWN, OR LOCATION 4-23-59		STATE 4-23-59
21. I attended the deceased from <u>4-5-59</u> to <u>4-23-59</u> and last saw her/him alive on <u>4-23-59</u> Death occurred at <u>1:15 P m</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Robert W. Kiebert M.D.</u>			22b. ADDRESS <u>St. Joseph, Mo</u>		22c. DATE SIGNED <u>4-24-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Apr. 27, 59	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town, or county) (State) St. Joseph, Mo.
24. FUNERAL DIRECTOR <u>H. O. Schenfelder & Son R.D. 4.</u>		ADDRESS <u>St Joseph, mo.</u>	25. DATE RECD. BY LOCAL REG. <u>April 26, 1959</u>		26. REGISTRAR'S SIGNATURE <u>Mr. Clark Gardell</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Health, Welfare Public Service
300
-57
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Doctor, coroner, etc., must use any other than black ink or ribbon type if possible.
All diseases in Part I must be causally related.
Dr. Robert W. Kiebert

FORM 2 2 NCPA

Dr Kieber

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 *W. William Harris*

Licensed Embalmer No. 4195.....

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.