

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

# 59-024489

## FILED VS AUG 13 1959

STATE FILE NUMBER

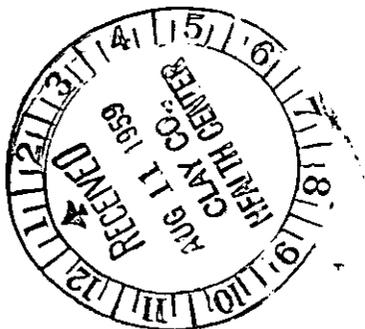
Registration District No. 71 Primary Registration District No. 3012 Registrar's No. 74

1. PLACE OF DEATH a. COUNTY <u>Clay</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clay</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Excelsior Springs</u>			Length of stay in 1b		c. CITY OR TOWN <u>301 High Bluff</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Thompson Avenue</u>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Excelsior Springs</u>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Lee</u> Last <u>VanBebber</u>				4. DATE OF DEATH Month <u>July</u> Day <u>24</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8-29-1880</u>	9. AGE (last birthday) <u>78</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Coal Miner</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Mining</u>		11. BIRTHPLACE (City and state or country) <u>Ray County</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>William VanBebber</u>			13b. MOTHER'S MAIDEN NAME <u>Susan G. Craven</u>			14. NAME OF HUSBAND OR WIFE <u>Mary Agnes Blann</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Mrs. J. L. VanBebber, Excelsior Springs, Mo.</u>			
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 <del>Thrombotic</del> Embolism</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							
DUE TO (b) <u>Thrombophlebitis of left arm</u>							<u>1 month</u>
DUE TO (c) <u>Arteriosclerosis</u>							<u>Unknown</u>
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 _____ p.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 <u>1957</u> to <u>24 July 1959</u> and last saw him alive on <u>24 July 1959</u> Death occurred at <u>4:10 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Ralph L. Dickahan, M.D.</u>				22b. ADDRESS <u>Excelsior Springs, Mo</u>		22c. DATE SIGNED <u>7/27/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>7-27-1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Salem</u>		23d. LOCATION (City, town, or county) (State) <u>Excelsior Springs, Missouri</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Prichard Funeral Home, Inc. Excelsior Springs, Missouri</u>				25. DATE RECD. BY LOCAL REG. <u>8-1-59</u>		26. REGISTRAR'S SIGNATURE <u>Caroline Nuechings</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF



**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

~~or by~~ \_\_\_\_\_ Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*Ralph Van Landingham*

Licensed Embalmer No. 24009

P. O. Address Galva, Ill.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.