

UNIFORM DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-035304

FILED VS. OCT 19 1959 42

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1028

STATE FILE NUMBER

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

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BUCHANAN</b>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>KANSAS</b> b. COUNTY <b>DONIPHAN</b>                            |  |   |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>ST. JOSEPH</b>  |  | Length of stay in 1b<br><b>40 MINUTES</b>   |  | c. CITY OR TOWN <b>WATHENA</b>   |  | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>ST. JOSEPH'S HOSPITAL</b>   |  |   |  | d. STREET ADDRESS (If outside, give location)<br><b>R. F. D. # 2</b>   |  | Reside on Farm<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>JOSEPH</b> Middle <b>HAROLD</b> Last <b>SHALZ</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>OCTOBER</b> Day <b>8</b> Year <b>1959</b>   |  |   |  |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b>       | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>OCT. 8, 1959</b>  | 9. AGE (last birthday)   | IF UNDER 1 YEAR<br>Months _____ Days _____  | IF UNDER 24 HR<br>Hours _____ Min. <b>40</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>--</b>  |  | 11. BIRTHPLACE (City and state or country)<br><b>ST. JOSEPH, MISSOURI</b>  |  | 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b>   |  |
| 13a. FATHER'S NAME<br><b>FRANCES SHALZ</b>  |  |   | 13b. MOTHER'S MAIDEN NAME<br><b>DOROTHY MILLER</b>       |  |  | 14. NAME OF HUSBAND OR WIFE<br><b>--</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO.<br><b>NONE</b>  |  | 17. INFORMANT<br><b>FRANCIS SHALZ</b> Address <b>WATHENA, KANSAS</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congenital Heart Disease (Eisenmenger's Syndrome) 40 min</b>   |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| 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)<br><b>Absent 4th clavicle, webbing 4th neck, absent 4th thumb, anomalous eyes</b>                             |  |   |  | PART III. If deceased was female was there a pregnancy in last 90 days:<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input 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<br>Hour _____ a.m. _____ p.m.   |  | Month, Day, Year _____  |  |  |  |   |  |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/><br>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 <b>birth</b> to <b>death</b> and last saw <sup>her</sup> <b>live</b> on <b>never</b><br>Death occurred at <b>12:40 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated. |  |   |  |  |  |   |  |
| 22a. SIGNATURE (Degree or title)<br><b>E. Yoder, M.D.</b>   |  |   | 22b. ADDRESS<br><b>Denton, Kans</b>                      |  |  | 22c. DATE SIGNED<br><b>12 Oct 59</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>REMOVAL</b>   |  | 23b. DATE<br><b>1959</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MT. CALVERY</b> |  | 23d. LOCATION (City, town, or county) (State)<br><b>WATHENA, KANSAS.</b> |   |  |
| 24. FUNERAL DIRECTOR<br><b>HARMAN FUNERAL HOME-WATHENA, KANSAS</b>  |  |   |  | 25. DATE RECD. BY LOCAL REG.<br><b>Oct. 12, 1959</b>   |  | 26. REGISTRAR'S SIGNATURE<br><b>Mrs. Clark Goodell</b>                                |  |

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 me  
or by \_\_\_\_\_ Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Charles M. Harman

Licensed Embalmer No. 4487

P.O. Address WATHENA, KANSAS

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.