

# I DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-000293

**FILED VS FEB 1 1960**

042

1000

105

STATE FILE NUMBER

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

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Buchanan</b> b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b> Length of stay in 1b <b>17 years</b> c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Josephs Hospital</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> -(Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Buchanan</b> c. CITY OR TOWN <b>St. Joseph</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (if outside, give location) <b>3005 S. 15th St.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>CYLDE</b> Middle _____ Last <b>COURTNER</b>			<b>4. DATE OF DEATH</b> Month <b>January</b> Day <b>24,</b> Year <b>1960</b>				
<b>5. SEX</b> male	<b>6. COLOR OR RACE</b> white	<b>7. Married</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> 9/5/1883	<b>9. AGE (last birthday)</b> 76	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Interior Decorator</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> 		<b>11. BIRTHPLACE</b> (City and state or country) <b>Shambaugh, Iowa</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> USA	
<b>13a. FATHER'S NAME</b> <b>Benjamin Courtner</b>			<b>13b. MOTHER'S MAIDEN NAME</b> unknown		<b>14. NAME OF HUSBAND OR WIFE</b> Mabel Courtner		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) no		<b>16. SOCIAL SECURITY NO.</b> unknown		<b>17. INFORMANT</b> Address <b>St. Joseph, Mo.</b> Mrs. Mabel Courtner, 3005 S. 15th,			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Auricular Fibrillation with Pulmonary Edema</b> DUE TO (b) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH Unk.		
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		
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)					
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>					
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b>		<b>COUNTY</b>	<b>STATE</b>		
<b>21. I attended the deceased from</b> <u>3/27/57</u> to <u>1/24/60</u> and last saw <del>her</del> him alive on <u>1/23/60</u> Death occurred at <u>4:15p.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> (Degree or title) <i>Arthur W. Hoenig MD</i>			<b>22b. ADDRESS</b> <b>Social Welfare Board</b> <b>10th &amp; Olive, St. Joseph, Mo.</b>		<b>22c. DATE SIGNED</b> 1/25/60		
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> removal	<b>23b. DATE</b> 1/27/1960	<b>23c. NAME OF CEMETERY OR CREMATORY</b>		<b>23d. LOCATION</b> (City, town, or county) (State) <b>Grant City, Missouri</b>			
<b>24. FUNERAL DIRECTOR</b> ADDRESS <i>Newton-Bowman</i> St. Joseph, Mo.			<b>25. DATE RECD. BY LOCAL REG.</b> Jan. 28, 1960	<b>26. REGISTRAR'S SIGNATURE</b> <i>Wm. Clark Goodell</i>			

DOCUMENT

O.W.D. Craig, M.D. 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 William Guldberg

Licensed Embalmer No. 4535

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.