

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-000377

FILED VS JAN 18 1960

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STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

DED

1. PLACE OF DEATH a. COUNTY Buchanan			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Buchanan		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in 1b 10 years	c. CITY OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1523 So. 11th St.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1523 S. 11th St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First GRACE Middle V. Last PICKARD			4. DATE OF DEATH Month January Day 8, Year 1960		
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 12/1/1887	9. AGE (last birthday) 72	IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HR 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 own home	11. BIRTHPLACE (City and state or country) Cleveland, Ohio		12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME George Stahl		13b. MOTHER'S MAIDEN NAME Elizabeth unknown		14. NAME OF HUSBAND OR WIFE William	
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. unknown		17. INFORMANT Mrs. Gertrude Swoboda, 1614 S. 38, St. Joseph, Address _____	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA					INTERVAL BETWEEN ONSET AND DEATH 3 DAYS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) SEVERE ANEMIA					1 MONTH
DUE TO (c) BLEEDING DUODENAL ULCER					1 MONTH
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 _____ Month, Day, Year _____ a.m. _____ p.m. _____	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 DECEMBER 1, 1959 to JAN 7, 1960 and last saw her alive on JAN. 7, 1960 Death occurred at 9:05 p. m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE L.H. Pifer, M.D. (Degree or title)			22b. ADDRESS 102 Farson St. Joseph		22c. DATE SIGNED 1-11-60
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 1/11/1960	23c. NAME OF CEMETERY OR CREMATORY Union Star Cemetery		23d. LOCATION (City, town, or county) (State) Union Star, Missouri	
24. FUNERAL DIRECTOR Hector Bowman ADDRESS St. Joseph, Mo.		25. DATE RECD. BY LOCAL REG. Jan. 13, 1960		26. REGISTRAR'S SIGNATURE Mrs. Clark Handell	

DOCUMENT

L.H. Pifer, M.D. MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JAN 9

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 Spaulding

Licensed Embalmer No. 4535

P. O. Address St Joseph

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