

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-010238

FILED VS APR 14 1960

Registration District No. 59 Primary Registration District No. _____ Registrar's No. 73 STATE FILE NUMBER

| | | | | | | | |
|--|---|---|--|---|-------------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Cass | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Cass | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Mt Pleasant | | Length of stay in 1b 16 Days | | c. CITY OR TOWN Mt Pleasant | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 328th USAF Hospital | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 5235 Clark Ave | | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Rosemary Middle Lucille Last Spiger | | | 4. DATE OF DEATH Month April Day 2 Year 1960 | | | | |
| 5. SEX Female | 6. COLOR OR RACE Cau | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 2 Dec 1919 | 9. AGE (last birthday) 40 | IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____ | IF UNDER 24 HR Months _____ Days _____ 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) Lind, Washington | | 12. CITIZEN OF WHAT COUNTRY USA | |
| 13a. FATHER'S NAME Fred Koch | | 13b. MOTHER'S MAIDEN NAME Marie Christel | | 14. NAME OF HUSBAND OR WIFE James A. Spiger | | | |
| 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. | | 17. INFORMANT 5235 Clark Ave James A. Spiger Richards-Gebaur AFB, Mo | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis DUE TO (b) Carcinoma, squamous cell, of cervix DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 1/2 mo | |
| 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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | |
| 19. WAS AUTOPSY PERFORMED? 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 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 22 September 1959 to 2 April 1960 and last saw her alive on 2 April 1960 Death occurred at 5:10 PM on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE <i>W.W. Koon</i> (Degree or title) Capt., USAF, MC | | | 22b. ADDRESS 328th USAF Hospital Richards-Gebaur AFB, Mo. | | 22c. DATE SIGNED 4 Apr 60 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE 6 April 1960 | 23c. NAME OF CEMETERY OR CREMATORY National Cemetery | | 23d. LOCATION (City, town, or county) Ft. Leavenworth, Kansas | | | |
| 24. FUNERAL DIRECTOR E. K. George & Son, Grandview, Mo. | | | 25. DATE RECD. BY LOCAL REG. April-7-1960 | 26. REGISTRAR'S SIGNATURE <i>Mrs Ray Seboe</i> | | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS APR 14 1980

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

Sterling E. Edda

Licensed Embalmer No. 4911

P. O. Address Grandview

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.