

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-018475

FILED VS. JUN 13 1960 042

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STATE FILE NUMBER

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

| | | | | | | | |
|--|--|---|---|--|--|--|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | | | |
| a. COUNTY Buchanan | | b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph | | a. STATE Mo | | b. COUNTY Buchanan | |
| Length of stay in 1b 5oyrs | | c. CITY OR TOWN St. Joseph | | d. STREET ADDRESS (If outside, give location) Green Acres Rt #3 | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hospital #2 | | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Oleo Elen Stevens | | | | 4. DATE OF DEATH May 30, 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 May 30, 1899 | |
| 9. AGE (last birthday) 61 | | 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) House keeper | | 10b. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (City and state or country) Princeton Mo | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13a. FATHER'S NAME Orin O'Harra | | | 13b. MOTHER'S MAIDEN NAME Edith Williams | | | 14. NAME OF HUSBAND OR WIFE deceased | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT Address Eldyne O'Harra St. Joseph, Mo | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) Pyonephritis | | | | | | 3 months | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Chronic Cystitis | | | | | | 6 months | |
| DUE TO (c) General Debility | | | | | | 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 checked="" 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 a.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 May 11, 1960 to May 30, 1960 and last saw her May 30, 1960 4 45 P.M. <input type="checkbox"/> him <input type="checkbox"/> alive on | | | | Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) Mohammad Tahir M.D. | | | | 22b. ADDRESS State Hosp. #2 St. Joseph, | | 22c. DATE SIGNED 5/30/60 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 6/1/60 | | 23c. NAME OF CEMETERY OR CREMATORY Ebenezer Cemetery | | 23d. LOCATION (City, town, or county) (State) St. Joseph, Mo | |
| 24. FUNERAL DIRECTOR John Rupp | | ADDRESS St. Joseph, Mo | | 25. DATE RECD. BY LOCAL REG. June 6, 1960 | | 26. REGISTRAR'S SIGNATURE Mr. Clark Woodell | |

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

John E. Rupp

Licensed Embalmer No. *3986*

P. O. Address *St. Joseph*

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.