

FEDERAL BUREAU OF INVESTIGATION - DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 8 1960

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-60-025975

STATE FILE NUMBER

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

1. PLACE OF DEATH a. COUNTY Buchanan				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan				
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in 1b 2 yrs.		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 2907 Edmond St.,			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (if outside, give location) 2907 Edmond St.,		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Joseph Middle Isadore Last Waller				4. DATE OF DEATH Month August Day 2, Year 1960				
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH Nov. 12, 1878	9. AGE (last birthday) 81	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) Self employed			10b. KIND OF BUSINESS OR INDUSTRY Farmer		11. BIRTHPLACE (City and state or country) Easton, Missouri		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Albert Waller			13b. MOTHER'S MAIDEN NAME Rose Beck			14. NAME OF HUSBAND OR WIFE Elda Waller		
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. 497-40-5802		17. INFORMANT Address Mrs. Elda Waller, St. Joseph, Missouri			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION							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) _____ DUE TO (c) _____								
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 SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 July 30, 1960 to Aug 3, 1960 and last saw her/him alive on July 29, 1960 Death occurred at 10:15 A a.m. on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) L.H. Pifer, M.D.				22b. ADDRESS 302 Faran			22c. DATE SIGNED 8-4-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE Aug. 4, 1960	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery		23d. LOCATION (City, town, or county) (State) St. Joseph, Missouri			
24. FUNERAL DIRECTOR ADDRESS W. H. Pifer & Son, Inc. St. Joseph, Mo.				25. DATE RECD. BY LOCAL REG. Aug 5, 1960		26. REGISTRAR'S SIGNATURE Wm. Clark Goodell		

DOCUMENT

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

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

Lisa J. Chaney

Licensed Embalmer No. 4679

P. O. Address St Joseph

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.