

VITAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 19 1960

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956

-60-022853

STATE FILE NUMBER

033853

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, Missouri		a. STATE Missouri		b. COUNTY Buchanan	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph Hospital		Length of stay in lb Life		c. CITY OR TOWN St. Joseph, Missouri		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1003 South 11th Street		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First CHRISTOPHER		Middle JOSEPH		Last BUCEK		Month Day Year September 7, 1960	
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9/6/1960	9. AGE (last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (City and state or country) St. Joseph, Missouri		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Benjamin J. Buczek			13b. MOTHER'S MAIDEN NAME Margaret Danback		14. NAME OF HUSBAND OR WIFE None		
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. None		17. INFORMANT Benjamin J. Buczek 1003 So. 11th Street		
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) congenital eversion due							
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							
DUE TO (b) to absence of anterior						1 day	
DUE TO (c) abdominal wall							
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 a.m. p.m. Month, Day, Year							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 9-6-60 to 9-7-60 and last saw him alive on 9-7-60 Death occurred at 3:15 a m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (In care or title) <i>Clement C. Johnson MD</i>				22b. ADDRESS <i>St Joseph MO</i>		22c. DATE SIGNED 9-8-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9/7/1960	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town, or county) (State) St. Joseph, Missouri			
24. FUNERAL DIRECTOR <i>Heaton Bowman</i>			ADDRESS St. Joseph, Missouri		25. DATE RECD. BY LOCAL REG. Sept 9, 1960		26. REGISTRAR'S SIGNATURE <i>Mr. Clark Goodell</i>

DOCUMENT

C.C. DuMont, 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 Spalding* _____

Licensed Embalmer No. 4525

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.