

**FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

FILED VS OCT 3 1960

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**-60-033947**

STATE FILE NUMBER

DEED

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Buchanan</b>			<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>		Length of stay in 1b <b>life</b>	c. CITY OR TOWN <b>St. Joseph</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Josephs Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1020 Doniphan Ave.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) First <b>CINDY</b> Middle <b>M.</b> Last <b>STEWART</b>			<b>4. DATE OF DEATH</b> Month <b>September</b> Day <b>15,</b> Year <b>1960</b>				
<b>5. SEX</b> <b>female</b>	<b>6. COLOR OR RACE</b> <b>white</b>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input checked="" type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>9/15/1960</b>	<b>9. AGE (last birthday)</b> _____	<b>IF UNDER 1 YEAR</b> Months _____ Days _____		<b>IF UNDER 24 HR</b> Hours <b>3</b> Min. <b>30</b>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>	<b>11. BIRTHPLACE</b> (City and state or country) <b>St. Joseph, Mo.</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>USA</b>		
<b>13a. FATHER'S NAME</b> <b>Rollie R. Stewart</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>Darlene Higbee</b>		<b>14. NAME OF HUSBAND OR WIFE</b> _____			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>	<b>17. INFORMANT</b> Address <b>Rollie Stewart, 1020 Doniphan Ave., St. Joseph</b>				
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGENITAL ATELECTASIS.</b> DUE TO (b) <b>PREMATURITY</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <b>3 1/2. 30 MIN.</b>		
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			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)					
<b>20c. TIME OF INJURY</b> Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____	<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b>	<b>COUNTY</b>	<b>STATE</b>		
<b>21. I attended the deceased from</b> <u>9/15/60</u> to <u>9/15/60</u> and last saw her alive on <u>9/15/60</u> Death occurred at <u>7:00 p.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> (Degree or, title) <i>John T. Rogers M.D.</i>			<b>22b. ADDRESS</b> <b>602 JONES ST. JOSEPH, MO</b>		<b>22c. DATE SIGNED</b> <b>9/19/60</b>		
<b>23a. BURIAL, CREMATION, REMOVAL, (Specify)</b> <b>burial</b>	<b>23b. DATE</b> <b>9/17/1960</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Ashland Cemetery</b>	<b>23d. LOCATION</b> (City, town, or county) (State) <b>St. Joseph, Missouri</b>				
<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>Wesley Bowman, St. Joseph, Mo.</b>		<b>25. DATE RECD. BY LOCAL REG.</b> <b>Sept. 23, 1960</b>	<b>26. REGISTRAR'S SIGNATURE</b> <i>Wm. Clark Goodell</i>				

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 William Spalding

Licensed Embalmer No. 4535

P. O. Address St Joseph Mo

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