

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-009454

1675

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No.

FILED FEB 21 1963

VS 300
Rev. 4/59

1

3

4

5

6

7

8

9

10

11

12

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Kansas b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis,		Length of stay in 1b 4 days	c. CITY OR TOWN Atchison, Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF DECEASED (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis-Elliott Rock Hospitals, Inc.,		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 824 No. 2nd St., Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Leo Middle Joseph Last Still			4. DATE OF DEATH Month Feb. Day 13, Year 1963
5. SEX Male	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 Feb. 16, 1897
9. AGE (last birthday) 65 yrs.		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) Switchman		10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (City and state or country) Kansas
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME Matthias Still	
13b. MOTHER'S MAIDEN NAME Frances Prenger		14. NAME OF HUSBAND OR WIFE Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates) Yes W.W. # 1		16. SOCIAL SECURITY NO. 75	17. INFORMANT Mrs. George Leathers, Atchison, Kansas. Address
18. CAUSE OF DEATH (Enter only one cause) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure chronic congestive arteriosclerotic heart disease			INTERVAL BETWEEN ONSET AND DEATH 2 mos.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 4200			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Bronchial asthma		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 type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION Atchison, Kansas
21. I attended the deceased from Feb. 9, 1963 to Feb. 13, 1963 and last saw her/him alive on Feb. 13, 1963 Death occurred at 4:45 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>R. Greiner, M.D.</i> (Degree or title)		22b. ADDRESS 770 Pac. Hospital 1755 South Grand Blvd.,	22c. DATE SIGNED 2/15/63
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 2-15-63	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) Atchison, Kansas.
24. FUNERAL DIRECTOR Albert H. Hoppe, Inc., ADDRESS 4700 Washington St. Louis, Mo.		25. DATE RECD. BY LOCAL REG. FEB 15 1963	26. REGISTRAR'S SIGNATURE <i>Paul Smith, M.D.</i>

USE BLACK INK
OR
TYPEWRITER RIBBON

69

87.50.8

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed JAMES M. INBLEY
Licensed Embalmer No. 3683

P. O. Address St Louis 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.