

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=63-019206

STATE FILE NUMBER

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 682

DO NOT WRITE ON THIS STUB

AMENDED

FILED JUN 12 1963

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 55 years	c. CITY OR TOWN St. Joseph Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Methodist Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) R. R. #2 Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) ELIZABETH SULLENDER		4. DATE OF DEATH Month May Day 28 Year 1963	
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 7/15/1878
9. AGE (last birthday) 82		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (City and state or country) Little York, Ind.
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME Joshua Warriner	
13b. MOTHER'S MAIDEN NAME Elizabeth Shields		14. NAME OF HUSBAND OR WIFE George	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of NO		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Gertrude Kiess, R. R. #2, St. Joseph, Mo.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive failure secondary to to arteriosclerotic cardiovascular disease and Myxothera Gravis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) ? DUE TO (c) ?			INTERVAL BETWEEN ONSET AND DEATH
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 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 5-28-63 to 5-28-63 and last saw her ^{alive} on 5-28-63 Death occurred at 1:00 p. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>[Signature]</i> (Degree or title)		22b. ADDRESS 316 10th St Joseph Mo	22c. DATE SIGNED 6-7-63
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 6/1/1963	23c. NAME OF CEMETERY OR CREMATORY Maitland Cemetery	23d. LOCATION (City, town, or county) (State) Maitland Mo.
24. FUNERAL DIRECTOR Heston - Bowman	ADDRESS St. Joseph, Mo.	25. DATE RECD. BY LOCAL REG. June 10, 1963	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

M.B. ROST, M.D.

USE BLACK INK OR TYPEWRITER RIBBON

205-10-100

REPORT NO. 02

ONE
MAY 19
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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

Eugene Wood

Licensed Embalmer No.

3804

P. O. Address

314 5610th 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.