

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-013230

STATE FILE NUMBER

FILED APR 20 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1612

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| 1. PLACE OF DEATH a. COUNTY Jackson | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN Kansas City |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 715 E. 47th St. | | Length of stay in lb unk. | d. STREET ADDRESS (If outside, give location) 715 East 47th St. |
| | | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|--|---------------------------|----------------------|-----------------------|------------------|---------------------|--|
| 3. NAME OF DECEASED (Type or print) | | | 4. DATE OF DEATH | | | |
| First JOHN | Middle MITCHELL | Last COMBS | Month March | Day 30 | Year 1959 | |

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|-----------------------|----------------------------------|---|---------------------------------|--|--------------------------------|--------------------------------|
| 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 unk. | 9. AGE (In years last birthday) 40 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) unknown | 12. CITIZEN OF WHAT COUNTRY? U. S. A. |
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| 13a. FATHER'S NAME COMBS | 13b. MOTHER'S MAIDEN NAME RUTH M. | 14. NAME OF HUSBAND OR WIFE |
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| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT Walter Garth, 715 E. 47th St., K.C. Mo. |
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| 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 |
| 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) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2 |

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| 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.) |
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| 20c. TIME OF INJURY Hour . Month, Day, Year a.m. p.m. | |
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| 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 _____, to _____ and last saw her/him alive on _____
Death occurred at **3:30 A.** m on the date stated above; and to the best of my knowledge, from the causes stated.

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| 21a. SIGNATURE (Degree or title) Hugh H. Owens | 21b. ADDRESS 1034 Park to Blvd | 21c. DATE SIGNED 3-30-59 |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE MARCH 30, 1959 | 23c. NAME OF CEMETERY OR CREMATORY - | 23d. LOCATION (City, town, or county) (State) WEBB CITY MISSOURI |
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| 24. FUNERAL DIRECTOR D.W. Newcomer's Sons, K.C. Missouri | 25. DATE RECD. BY LOCAL REG. 3-30-59 | 26. REGISTRAR'S SIGNATURE neva mitchell |
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

Hugh H. Owens

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 *Robert Ray*

Licensed Embalmer No. *4182*
P. O. Address *K.C., 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.