

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-010740

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1684

FILED APR 5 1962

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Rev. 4/59

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DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Jacob Kraft

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <b>Jackson</b>		a. STATE <b>Missouri</b>	b. COUNTY <b>Jackson</b>
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Kansas City</b>		c. CITY OR TOWN <b>Kansas City</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>Menorah Medical Center</b>		d. STREET ADDRESS <b>2723 Highland</b>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First <b>Lela</b> Middle <b>Askew</b> Last <b>Askew</b>		Month <b>March</b> Day <b>24</b> Year <b>1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>9-16-06</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Minister</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) <b>55</b>
11a. FATHER'S NAME <b>Charles Brown</b>		11b. MOTHER'S MAIDEN NAME <b>Rosa Davis</b>	11c. BIRTHPLACE (City and state or country) <b>Louisiana</b>
12a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, <u>u</u> unknown)		12b. SOCIAL SECURITY NO. <b>-</b>	12c. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13. NAME OF HUSBAND OR WIFE <b>Clarence Askew</b>		17. INFORMANT Address <b>Clarence Askew Kansas City Mo.</b>	
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) <b>Massive pulmonary artery embolism</b>			<b>5 min</b>
DUE TO (b) <b>Thrombosis femoral veins, bilateral</b>			<b>2 weeks</b>
DUE TO (c) <b>Abdominal carcinoma, primary</b>			<b>1 year</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
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 <b>2:30</b> a.m. p.m.		Month, Day, Year <b>March 24, 1962</b>	
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 <b>Feb 27, 1962</b> to <b>March 24, 1962</b> and last saw her alive on <b>March 23, 1962</b> Death occurred at <b>2:30 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Jacob Kraft, M.D.</b> (Degree or title)		22b. ADDRESS <b>701 E 63rd St.</b>	22c. DATE SIGNED <b>3/25/62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>3/28/1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Kansas City, Jackson. Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Bailey Funeral Home, K.C. Kansas</b>		25. DATE RECD. BY LOCAL REG. <b>3.26.62</b>	26. REGISTRAR'S SIGNATURE <b>Ruth Long</b>

**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 Laurene A Jones

Licensed Embalmer No. 4829

P. O. Address 7315 Fenwick

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.