

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-011229

STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1448

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1448

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 60 years	c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION D.O.A. St. Lukes		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4307 Troost Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last ROBERTA M. O'BRIEN			4. DATE OF DEATH Month Day Year 3-10-1962
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3-5-1874 9. AGE (last birthday) 88 years
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (City and state or country) Cape Girardeau, Mo. 12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Edmund K. O'Brien		13b. MOTHER'S MAIDEN NAME Sarah G. Gale	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	17. INFORMANT Address Mrs. Viola O'Brien 5127 Troost
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myenteric Thrombosis DUE TO (b) Generalized Arteriosclerosis 5 yrs DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 3 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease (When given in PART I.) Arteriosclerotic Heart Disease			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 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 10/28/57 to 3/10/62 and last saw her alive on 3/10/62 Death occurred at 2:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Robert W. Hamill MD (Degree or title)		22b. ADDRESS Kansas City Mo	
22c. DATE SIGNED 3/12/62 (State)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3-13-1962	23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery	23d. LOCATION (City, town, or county) (State) Kansas City, Mo.
24. FUNERAL DIRECTOR ADDRESS WAGNER FUNERAL HOME K.C. Mo.		25. DATE RECD. BY LOCAL REG. 3-12-62	26. REGISTRAR'S SIGNATURE Ruth Long

VS 300 Rev. 4/59
1
2 **3638**
3
4 **1**
5 **0**
6
7 **0**
8 **0**
94500
10
11
1292-0
13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

SHOULD READ

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

Robert W. Hamill

USE BLACK INK OR TYPEWRITER RIBBON

JE 1-20-30

W. HAMMILL RD. 4320

12:30 - 5:50

ROBT. HAMMILL

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 A. R. Hammschild

Licensed Embalmer No. 4159

P. O. Address H. E. 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.