

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-011537
STATE FILE NUMBER

Registration District No. 150 Primary Registration District No. 5572 Registrar's No. 33

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1 7000
2 7000
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|
| FILED MAR 29 1962 | | 1. PLACE OF DEATH a. COUNTY Jackson | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Jackson | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Prarie Township | | Length of stay in 1b 11 yrs | | c. CITY OR TOWN Independence Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jackson County Home | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) Jackson County Home Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First OSCAR Middle OWENS Last | | | 4. DATE OF DEATH Month 3 Day 23 Year 1962 | | |
| 5. SEX male | 6. COLOR OR RACE Negro | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 1881 | 9. AGE (last birthday) 81 yrs | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer | | 10b. KIND OF BUSINESS OR INDUSTRY construction | | 11. BIRTHPLACE (City and state or country) Oklahoma | |
| 12. CITIZEN OF WHAT COUNTRY U S A | | 13a. FATHER'S NAME unknown | | 13b. MOTHER'S MAIDEN NAME unknown | |
| 14. NAME OF HUSBAND OR WIFE unknown | | 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 Jackson County Home records | | Address Indep | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) influenza | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 days |
| 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) | | | | 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 3 19 1962 to 3 23 1962 and last saw him alive on 3 23 1962 Death occurred at 6:00 A M on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE <i>S. H. Greffis</i> | | (Degree or title) M.D. | | 22b. ADDRESS Rt. 3 Zone 39 K. C. Mo. | |
| 22c. DATE SIGNED 3 25 62 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE Mar. 26, 1962 | 23c. NAME OF CEMETERY OR CREMATORY Anatomical Osteopathic Collage | | 23d. LOCATION (City, town, or county) (State) Kansas City, Missouri | |
| 24. FUNERAL DIRECTOR C. K. Kerford | | ADDRESS F. H. K. C. Mo. | | 25. DATE RECD. BY LOCAL REG. 3-29-1962 | 26. REGISTRAR'S SIGNATURE <i>Mustardwiler M.D.</i> |

USE BLACK INK OR TYPEWRITER RIBBON

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 *Clarence Reynolds*

Licensed Embalmer No. 4437

P. O. Address *RCMO*

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.