

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-019002

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2536 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED JUN 8 1962	
1. PLACE OF DEATH a. COUNTY <u>Jackson</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u> Length of stay in lb <u>10 yrs</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>3720 MAIN</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u> c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>3720 MAIN</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Enola</u> Middle <u>Maude</u> Last <u>Rogers</u>	
4. DATE OF DEATH Month <u>MAY</u> Day <u>8</u> Year <u>1962</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>CAUC.</u>
7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 7, 1873</u>
9. AGE (last birthday) <u>89</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>
11. BIRTHPLACE (City and state or country) <u>Kansas</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>
13a. FATHER'S NAME <u>William Sampson</u>	13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>
14. NAME OF HUSBAND OR WIFE <u>Clarence S. Rogers</u>	Address <u>3720 MAIN</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>None</u>
17. INFORMANT <u>MRS. Atha Sperry</u>	Address <u>3720 MAIN</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral Metastasis</u> DUE TO (c) <u>Bronchogenic Carcinoma</u> 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 <u>  </u> a.m. <u>  </u> 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 <u>5-1960</u> to <u>5-8-62</u> and last saw her/him alive on <u>5-8-62</u> Death occurred at <u>7:25 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>Otto W. Theel M.D.</u>	22b. ADDRESS <u>4301 Main St. HCMo</u>
22c. DATE SIGNED <u>5-9-62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>MAY 11, 1962</u>
23c. NAME OF CEMETERY OR CREMATORY <u>Kincaid Cemetery</u>	
23d. LOCATION (City, town, or county) (State) <u>Kincaid Kansas</u>	
24. FUNERAL DIRECTOR <u>Muehlebach</u>	25. DATE RECD. BY LOCAL REG. <u>5-9-62</u>
26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>	

VS 300 Rev. 4/59

1  
3 488  
3  
4 1  
5 2  
6  
7 1  
8 2  
9 162.1  
10  
11  
12 90-0  
13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF Otto W. Theel

USE BLACK INK OR TYPEWRITER RIBBON

Dr. Orth's real

WE 1 - 3, 99

4301 Main

7:30 - 5:00 PM

**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

*R. E. Nichols*

Licensed Embalmer No. 4999

P. O. Address W. P. M.D.

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.