

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-023016

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2793

DO NOT WRITE ON THIS STUB

AMENDED

FILED JUN 21 1962

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF  
**ROBERT SKILLMAN**  
MEDICAL CERTIFICATION

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Kansas</u> b. COUNTY	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Length of stay in 1b <u>2 weeks</u>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Luke's Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>8925 W. 190th Terrace</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>RUTH ANN FALCONER</u>		4. DATE OF DEATH Month Day Year <u>May 21, 1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc.</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6/22/1948</u>
9. AGE (last birthday) <u>3</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and state or country) <u>Richmond, Virginia</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13. FATHER'S NAME <u>Thomas M. Falconer</u>	
13b. MOTHER'S MAIDEN NAME <u>Doris Devore</u>		14. NAME OF HUSBAND OR WIFE <u>Single</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 Address <u>Thomas M. Falconer, Overland Park, Kansas</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>Gastrointestinal Hemorrhage</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Shistosomiasis</u> DUE TO (c) <u>Acute Lymphatic Leukemia</u>			INTERVAL BETWEEN ONSET AND DEATH
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 Month, Day, Year			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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>May 1, 1962</u> to <u>5-24-62</u> and last saw her alive on <u>5-23-62</u> Death occurred at <u>12:15 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Robert Skillman M.D.</u>		22b. ADDRESS <u>Kansas City, Mo</u>	22c. DATE SIGNED <u>5-24-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>May 24, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Forest Lawn Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Richmond Virginia</u>
24. FUNERAL DIRECTOR ADDRESS <u>D.W. Newcomer's Sons, Kansas City, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>5-24-62</u>	26. REGISTRAR'S SIGNATURE <u>Ruth H Long</u>

Dr. Robert Skillman  
4320 Wornall  
11 AM Thursday

**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 James W. Lawson

Licensed Embalmer No. 4889

P. O. Address Lathrop, 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.