

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-026936 ✓

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

149  
 Registered District No. 1002 Primary Registration District No. 1002 Registrar's No. 3570

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>St. Charles</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in 1b <b>1 day</b>	c. CITY OR TOWN <b>St Charles</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>5212 E 8th St</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>315 No Benton</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>JAMES</b> Middle <b>Allen</b> Last <b>ARRAS</b>		Month <b>July</b> Day <b>7</b> Year <b>1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>5/10/83</b>
9. AGE (last birthday) <b>79</b>		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farmer</b>	11. BIRTHPLACE (City and state or country) <b>Cottleville Mo</b>
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13a. FATHER'S NAME <b>Adam Arras</b>	
13b. MOTHER'S MAIDEN NAME <b>Elizabeth hoffman</b>		14. NAME OF HUSBAND OR WIFE <b>Emma Arras</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		17. INFORMANT Address <b>allan arras St Charles Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b>			
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 _____ Month, Day, Year _____ a.m. _____ p.m. _____	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 _____ to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22. SIGNATURE (Degree or title) <i>Sheil H. Long</i>		22b. ADDRESS <b>152 Union Station</b>	
22c. DATE SIGNED <b>7-8-62</b>		22d. DATE SIGNED <b>7-6-62</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>7/7/1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St John's Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St Charles Missouri</b>	
24. FUNERAL DIRECTOR <b>Sheil Funeral Home Kansas City Mo</b>		25. DATE RECD. BY LOCAL REG <b>7-8-62</b>	
26. REGISTRAR'S SIGNATURE <i>Ruth H. Long</i>			

DATE AMENDED  
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 SHOULD READ  
 ITEM NO.

DOCUMENT  
 MEDICAL CERTIFICATION  
 BY AFFIDAVIT OF

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 Rev. 4/59  
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USE BLACK INK OR TYPEWRITER RIBBON

OCT 16 1962

*M. Rowland Jones*  
Owens

**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 \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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.