

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

3779-62-027037
STATE FILE NUMBER

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

FILED AUG 2 1962

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF Albert J. Deo MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Length of stay in 1b 40 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 ST. JOSEPH'S HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 8400 JARBOE Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last BLANCHE L. DE BANTO			4. DATE OF DEATH Month Day Year JULY 18 1962
5. SEX FEMALE	6. COLOR OR RACE CAUC.	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 13 1916
9. AGE (last birthday) 75 YEARS		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) CLERK (RETIRED)		10b. KIND OF BUSINESS OR INDUSTRY KLINES	11. BIRTHPLACE (City and state or country) MA MOUTH, ILL.
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME JAMES D MCNAMARA	
13b. MOTHER'S MAIDEN NAME MARY ANN SHUNICK.		14. NAME OF HUSBAND OR WIFE WM DE BANTO	
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. [REDACTED]	17. INFORMANT Address MR. AGORSCHERN 8400 JARBOE
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis			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) Chronic heart disease & mitral stenosis		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 6:55 to July 18, 1962 and last saw her alive on July 18, 1962		Death occurred at 9:10 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) Albert J. Deo M.D.		22b. ADDRESS Kansas City, Mo.	22c. DATE SIGNED 7/20/62
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 7-21-1962	23c. NAME OF CEMETERY OR CREMATORY ST. MARYS CEMETERY	23d. LOCATION (City, town, or county) (State) KANSAS CITY, MO.
24. FUNERAL DIRECTOR MUEHLBACH		ADDRESS 6800 TROOST.	25. DATE RECD. BY LOCAL REG. 7-20-62
		26. REGISTRAR'S SIGNATURE Ruth N Long	

USE BLACK INK OR TYPEWRITER RIBBON

DR's Ketchum, Hunter & Decker
Walshheim Bldg.
VI 2-6708

120 = 5

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. 4997

P. O. Address K. P. No

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.