

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-030900

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **187** Primary Registration District No. **1002** Registrar's No. **4189** STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

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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

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

James W. Vaughn

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) Kansas City		Length of stay in lb 20 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 Neurological Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 428 East 65th Terr. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First DONA Middle V. Last COOPER		4. DATE OF DEATH Month August Day 12 Year 1962	
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8-7-1888
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	9. AGE (last birthday) 74 IF UNDER 1 YEAR: Months Days IF UNDER 24 HR: Hours Min.
11a. BIRTHPLACE (City and state or country) Elm, Missouri		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Theodore		13b. MOTHER'S MAIDEN NAME Cora Corder	
14. NAME OF HUSBAND OR WIFE Alfred L. Cooper		17. INFORMANT Address Alfred J. Cooper, 428 E. 65 Terr., K.C. Mo	
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]	
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHO PNEUMONIA			INTERVAL BETWEEN ONSET AND DEATH ABOUT 1 DAY
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 BRAIN SYNDROME ASSOCIATED WITH CEREBRAL ARTERIOSCLEROSIS			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 7/11/62 to 8/12/62 and last saw ^{her} alive on 8/11/62 Death occurred at 7:10 A. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) James W. Vaughn M.D.		22b. ADDRESS 2625 W Paseo KC, Mo	
22c. DATE SIGNED 8/13/62			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Aug. 15, 1962	23c. NAME OF CEMETERY OR CREMATORY Floral Hills Cemetery	23d. LOCATION (City, town, or county) (State) Kansas City Missouri
24. FUNERAL DIRECTOR D.W. Newcomer's Sons		25. DATE RECD. BY LOCAL REG. 8-14-62	26. REGISTRAR'S SIGNATURE Ruth Long

Dr. James Vaughan
2625 West 34th - Neurological Hospital
10400-1200

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 Vaughan*

Licensed Embalmer No. 4096
P. O. Address K. C. 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.