

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-038577

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 1002 Ordinary Registration District No. 1002 Registrar's No. 5240 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED OCT 25 1962

VS 300
Rev. 4/59

1

2 3888

3

4 1

5 2

6

7 0

8 1

9 4214

10

11

12 90-0

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

BY AFFIDAVIT OF

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 53 yrs	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 6921 Agnes		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 6921 Agnes Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Mary Middle Ann Last Berntsen			4. DATE OF DEATH Month Oct Day 16 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 1-24-1878
9. AGE (last birthday) 84		IF UNDER 1 YEAR Months _____ Days _____ Hours _____	IF UNDER 24 HR Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Platte County, Mo.
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME Abraham Leppard	
13b. MOTHER'S MAIDEN NAME Missouri Ann Saunders		14. NAME OF HUSBAND OR WIFE William H. Berntsen	
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. None	17. INFORMANT Mrs. Berenice Kelly, 6911 Agnes Address K. C. Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1. Valvular Heart Disease DUE TO (b) 2. Arteriosclerosis, gen DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 10 yrs.
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 checked="" type="checkbox"/> NO <input 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 Mar. 15, 1954 to Oct. 16, 1962 and last saw her/him alive on Oct. 15, 1962 Death occurred at 6 - P.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Paul E. Pearson M.D. (Degree or title)		22b. ADDRESS 5820 Shaw Dr. Merriam, Mo	22c. DATE SIGNED 10/16/62
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10-19-1962	23c. NAME OF CEMETERY OR CREMATORY Floral Hills	23d. LOCATION (City, town, or county) Kansas City, Missouri (State)
24. FUNERAL DIRECTOR Floral Hills Memorial Chapels, Inc Blue Ridge & Gregory		25. DATE RECD. BY LOCAL REG. 10-16-62	26. REGISTRAR'S SIGNATURE Ruth Long

31st + My as date
Dr. Powell Pearson
Hrs

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 E. M. Jones

Licensed Embalmer No. 3453

P. O. Address H. C. Kane

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.