

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-039077

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 196 Primary Registration District No. 2026 Registrar's No. 479

FILED OCT 16 1962							
1. PLACE OF DEATH a. COUNTY Jackson b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Independence Length of stay in lb Life c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION D.O.A. Indep. Hospital Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Jackson c. CITY OR TOWN R.R.#4 Lees Summit Rd. Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) R.R.#4 Lees Summit Rd. Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First MR. JOSEPH Middle MICHAEL Last CASEY							
4. DATE OF DEATH Month October Day 6 Year 1962							
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH June 9, 1903	9. AGE (last birthday) 59	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Jackson Co., Mo.		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Michael Casey			13b. MOTHER'S MAIDEN NAME Mary Maloney			14. NAME OF HUSBAND OR WIFE ---	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes N.W.#11		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Mrs. Earl Edison, Indep., 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) Crushed Chest & Neck 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) History of Sepsis 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						INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input checked="" 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.) swung @ car bench			
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year 10-6-62		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.) Highway		20f. CITY, TOWN, OR LOCATION COUNTY STATE Jackson MO	
21. I attended the deceased from _____ to _____ and last saw him alive on _____ Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Alma L. Craig			22b. ADDRESS 152 Union Station			22c. DATE SIGNED 10-8-62	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Oct. 9, 1962		23c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery		23d. LOCATION (City, town, or county) (State) Indep., Mo.	
24. FUNERAL DIRECTOR ADDRESS OTT & MITCHELL, Indep., Mo.			25. DATE RECD. BY LOCAL REG. 10-8-62		26. REGISTRAR'S SIGNATURE Alma L. Craig		

VS 300
 Rev. 4/59
 1 7005
 2 7000
 3 1
 4 0
 5 0
 6
 7 0
 8 2
 9 X
 10
 11 700
 12 92-3
 13 1-0

DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

OCT 23 1962

NOV 16 1962

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 Henry D. Mitchell

Licensed Embalmer No. 3925

P. O. Address Salem, 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.

10-8-62