

# MISSOURI DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-043041  
STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 557

**FILED NOV 26 1962**

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK  
OR  
TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Independence</b>		Length of stay in 1b <b>1 day</b>	c. CITY OR TOWN <b>Kansas City</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>Independence Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>5219 Marsh</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>MARK</b> Middle <b>ALLAN</b> Last <b>CLOSSER</b>			4. DATE OF DEATH Month <b>Novemeber</b> Day <b>18</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 checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>10/2/62</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) <b>16</b> IF UNDER 1 YEAR: Months <b>1</b> Days <b>16</b> IF UNDER 24 HR: Hours <b>16</b> Min.
11a. BIRTHPLACE (City and state or country) <b>Independence Mo</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>John E Closser</b>		13b. MOTHER'S MAIDEN NAME <b>Cordelia Comer</b>	
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) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>John E Closser 5219 Marsh K C Mo</b> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subarachnoid hemorrhage</b> DUE TO (b) <b>Cerebral mass - right motor area of brain</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>3 days?</b> <b>7 mos</b>
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 <b>Nov 19, 1962</b> to <b>Nov 18, 1962</b> and last saw <sup>her</sup> him alive on <b>Nov 17, 1962</b> Death occurred at <b>Nov 18 6 AM</b> m on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE <i>[Signature]</i> (Degree or title)	
22b. ADDRESS <b>1612 Truman Rd Independence, Mo</b>		22c. DATE SIGNED <b>11/19/62</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>11/20/62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt Olivet Cemetery</b>	23d. LOCATION (City, town, or county) <b>Kansas City Missouri</b> (State)
24. FUNERAL DIRECTOR <b>Sheil Colonial Chapel K C Mo</b>		25. DATE RECD. BY LOCAL REG. <b>11-19-62</b>	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>

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Independence Hospital

November 18 1901

CLARENCE

WALTON

MARK

1 16

1901

White

Male

Independence Mo USA

First

Independence

John F. Closser

John F. Closser 2519 Warren K. C. No.

Home

No.

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. 656

working under my personal supervision.

Student Jimmy S. Birch  
Signature of Student Embalmer

Signed Thomas A. Sheil

Licensed Embalmer No. 4954

P. O. Address 500 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.

Funeral Home at Olivet Cemetery, Kansas City, Missouri

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