

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-001419

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 206

DO NOT WRITE ON THIS STUD AMENDED

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY JACKSON		a. STATE KANSAS b. COUNTY JOHNSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) KANSAS CITY		c. CITY OR TOWN SHAWNEE MISSION	
Length of stay in lb 1 hr		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) St Lukes Hospital		d. STREET ADDRESS (If outside, give location) 2723 W. 51st St.	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH
First MARIE Middle ANGEVINE Last ANGEVINE			Month Jan. Day 10 Year 1963
5. SEX	6. COLOR OR RACE	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH
Female	white		11/17/1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country)
Housework		own home	Mankato, Ks
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME	
Clinton Angevine		Nettie John	
14. NAME OF HUSBAND OR WIFE		none	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Address
no			Mrs Olive Stote 5400 State Line K.C.Ks.
18. CAUSE OF DEATH (Enter only one cause per line)			INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:			3 Hours
IMMEDIATE CAUSE (a) Cerebral Hemorrhage - acute - massive - severe			
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)			PART III. If deceased was female was there a pregnancy in last 90 days.
Generalized Arteriosclerosis with extensive Cerebral arteriosclerosis			<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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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 7-16-58 to 1/10/63 and last saw her ^{her} his alive on 1/10/63			
Death occurred at 8P m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE		22b. ADDRESS	22c. DATE SIGNED
<i>John H. Wheeler</i> (Degree or title) MD		4320 Wornall K.C.Mo	1/11/63
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
removal	1/12/63	Highland Park Cemetery	K.C.Ks.
24. FUNERAL DIRECTOR ADDRESS		25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE
JOS. A. BUTLER'S SONS K.C.K		1-14-63	<i>Keith Long</i>

VS 300 Rev. 4/59

1
2 **8450**
3
4 **1**
5 **0**
6
7 **1**
8 **2**
9 **9331X**
10
11
12 **66-0**
13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF **John H. Wheeler** MEDICAL CERTIFICATION

USE BLACK INK OR TYPEWRITER RIBBON

2018 11 15 10:30 AM

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 *Tom Keene*

Licensed Embalmer No. 3426 Mo

P. O. Address Ke Kanna

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.