

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-001575

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 339

DO NOT WRITE ON THIS STUB AMENDED

VS 300 Rev. 4/59	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF	DOCUMENT	BY AFFIDAVIT OF	L. O'Connell MEDICAL CERTIFICATION
1					
23 X 48					
3					
4 1					
5 2					
6					
7 2					
8 2					
9 260X					
10					
11					
12 67-0					
13					
ITEM NO.	SHOULD READ				

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Jackson			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 71 yrs		c. CITY OR TOWN Kansas City	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Mary's Hosp		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 4404 East 112 th St	
3. NAME OF DECEASED (Type or print) First Louisa Middle Mary Last Frank		4. DATE OF DEATH Month Jan Day 18 Year 1963			
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 7/2/1863	9. AGE (last birthday) 99	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (City and state or country) Austria	
12. CITIZEN OF WHAT COUNTRY U S A		13a. FATHER'S NAME Stogbauer		13b. MOTHER'S MAIDEN NAME no record	
14. NAME OF HUSBAND OR WIFE Henry Frank, deceased		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of servi) No			
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Anna Dunn Address 4404 East 112th St K.C., Mo.			
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Thrombosis					INTERVAL BETWEEN ONSET AND DEATH 24 hr
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					DUE TO (b) Generalized & Cerebral Arteriosclerosis 15 yrs.
					DUE TO (c) Diabetes Mellitus
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 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 1960 to 1-18-63 and last saw her alive on 1-17-63 Death occurred at 5:30 PM m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE G. L. O'Connell M.D. (Degree or title)		22b. ADDRESS 7830 State Line Shawnee Mission, Ks.		22c. DATE SIGNED 1-19-63	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/21/1963	23c. NAME OF CEMETERY OR CREMATORY St. Mary's		23d. LOCATION (City, town, or county) (State) Kansas City Missouri
24. FUNERAL DIRECTOR Wagner Funeral Home ADDRESS K.C., Mo.		25. DATE RECD. BY LOCAL REG. 1-19-63		26. REGISTRAR'S SIGNATURE Ruth Long	

USE BLACK INK OR TYPEWRITER RIBBON

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 Alvin R. Haverstick

Licensed Embalmer No. 4159

P. O. Address H. E. MD

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.