

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-001780

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 159

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Walter Harvey

USE BLACK INK OR TYPEWRITER RIBBON

| | | | | | | | |
|--|--|---|--|---|--|--|-------------------------|
| FILED JAN 28 1963 | | 1. PLACE OF DEATH a. COUNTY - Jackson | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Jackson | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City | | Length of stay in 1b 61 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 DOA Downtown Hospital | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 1004 Locust | | | |
| 3. NAME OF DECEASED (Type or print) First Frank Middle R. Last Paxton | | | 4. DATE OF DEATH Month 1 Day 8 Year 63 | | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 10-25-1901 | 9. AGE (last birthday) 61 | IF UNDER 1 YEAR Months | IF UNDER 24 HR Days | IF UNDER 24 HR Hours |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, "even if retired") taxi driver | | 10b. KIND OF BUSINESS OR INDUSTRY - | | 11. BIRTHPLACE (City and state or country) Kansas City Mo USA | | 12. CITIZEN OF WHAT COUNTRY | |
| 13a. FATHER'S NAME Frank R. Paxton | | 13b. MOTHER'S MAIDEN NAME Mary Burk | | 14. NAME OF HUSBAND OR WIFE Ada | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) no | | 16. SOCIAL SECURITY NO. [redacted] | | 17. INFORMANT Ada Paxton 1004 Locust | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) Cardiac arrhythmia | | | | | | Minutes. | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Coronary artery arteriosclerosis | | | | | | Several years. | |
| DUE TO (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Pulmonary Emphysema | | | | | 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 July 1962 to January 1963 and last saw ^{them} him alive on 1/7/63 Death occurred at 11:00 A m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE Walter Harvey Jacobs, Sr. D. | | | 22b. ADDRESS 751-E-63rd St. Kansas City, Mo | | | 22c. DATE SIGNED 1/9/63 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 1-10-1963 | 23c. NAME OF CEMETERY OR CREMATORY Forest Hill Cem. | | 23d. LOCATION (City, town, & county) Kansas city mo | | (State) |
| 24. FUNERAL DIRECTOR Kassantins Snow KC, Mo | | ADDRESS | | 25. DATE RECD. BY LOCAL REG. 1-10-63 | 26. REGISTRAR'S SIGNATURE Ruth Long | | |

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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 *R. Passantino*

Licensed Embalmer No. 4554
P. O. Address RC 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.