

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-001882
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 254

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

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF Paul R. Young MEDICAL CERTIFICATION

USE BLACK INK OR TYPEWRITER RIBBON

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) Kansas City		c. CITY OR TOWN Raytown	
Length of stay in 1b 12 YEARS		Inside Limits <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Blue Ridge Nursing Home		d. STREET ADDRESS (If outside, give location) 8720 East 79th Terr.	
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) First TRA Middle STOKES Last			4. DATE OF DEATH Month January Day 13 Year 1963
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 10-29-1880
9. AGE (last birthday) 82	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		11. BIRTHPLACE (City and state or country) Sedalia, Mo.
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY Farming	12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME Henry Stokes		13b. MOTHER'S MAIDEN NAME Amie Powell	
14. NAME OF HUSBAND OR WIFE Ella Stokes		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Fern Johnston 8720 East 79th Terr.	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident			INTERVAL BETWEEN ONSET AND DEATH 24 hrs
DUE TO (b) Generalized arteriosclerosis			Unk.
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Bronchopneumonia			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 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 <u>1 September 62</u> , to <u>13 Jan 63</u> and last saw her/him alive on <u>13 Jan 63</u> Death occurred at <u>11:00 P.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Paul R. Young M.D.</i>		22b. ADDRESS 9406 E. 63rd St. Raytown Mo	22c. DATE SIGNED 15 Jan 63
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 1-16-1963	23c. NAME OF CEMETERY OR CREMATORY Green Lawn	23d. LOCATION (City, town, county) (State) Kansas City, Missouri
24. FUNERAL DIRECTOR Muehlebach 6800 Troost		25. DATE RECD. BY LOCAL REG. 1-15-63	26. REGISTRAR'S SIGNATURE <i>Ruth Long</i>

Dr. Paul R. Young
Raytown Clinic

FL-8-1060

11:00 to 12:00
Tuesday

1:30 to 5:00

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 Robert G. Landes

Licensed Embalmer No. 5103

P. O. Address K. C. 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.

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