

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-006299
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 988

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

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF M. D. OSBORN
MEDICAL CERTIFICATION

FILED MAR 8 1963	
1. PLACE OF DEATH a. COUNTY Jackson	
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) Kansas City	Length of stay in lb 65 yrs
c. FULL NAME OF (If NOT in hospital, give location) St. Joseph Hospital	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. CITY OR TOWN Kansas City	
d. STREET ADDRESS (If outside, give location) 4319 Woodland	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ALONZO W. BALES	
4. DATE OF DEATH Month Feb. Day 12 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 Oct. 5, 1879
9. AGE (last birthday) 83	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Corn Products. Co.	10b. KIND OF BUSINESS OR INDUSTRY Nebraska City, Nebr.
11. BIRTHPLACE (City and state or country) U.S.A.	
12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME William Bales	13b. MOTHER'S MAIDEN NAME Sarah Sheppard
14. NAME OF HUSBAND OR WIFE Eugenia Bales	
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. Eugenia Bales, 4319 Woodland	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mycocarditis	
DUE TO (b) Acute Myocardial Infarction	
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. <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 checked="" 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 June 1960 to 2-12-63 and last saw ^{her} him alive on 2-12-63 Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE M. D. Osborn M.D.	22b. ADDRESS 4000 Baltimore
22c. DATE SIGNED 2-14-63	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Feb. 15, 1963
23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	
23d. LOCATION (City, town, or county) (State) Kansas City, Missouri	
24. FUNERAL DIRECTOR ADDRESS Mellody-McGilley-Eylar Funeral Home Woodland-Linwood	
25. DATE RECD. BY LOCAL REG. 2-14-63	26. REGISTRAR'S SIGNATURE Oruth Long

USE BLACK INK OR TYPEWRITER RIBBON

A. M. B. Cuslett
4000 Baltimore
Va 1-5115

12-30m Wed
1 pm Thurs for a
short time.

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 James R. Phillips
Licensed Embalmer No. 4641
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.