

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-006320

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 147 Primary Registration District No. 1002 Registrar's No. 1221 STATE FILE NUMBER

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 John H. Wheeler MEDICAL CERTIFICATION

|   |  |
|---|--|
| <b>FILED MAR 15 1963</b>  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Missouri JACKSON</u>  |  |
| 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>JACKSON</u>  |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only) Length of stay in 1b<br><u>Kansas City</u> <u>15 yrs</u>  |  |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION<br><u>St Lukes Hospital</u>   |  |
| d. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |  |
| e. STREET ADDRESS <u>3928 TERRACE</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED First Middle Last<br><u>ARTELIA JENNING BELL</u>  |  |
| 4. DATE OF DEATH Month Day Year<br><u>2 24 1963</u>   |  |
| 5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>   |  |
| 8. DATE OF BIRTH <u>3-31-1875</u> 9. AGE (last birthday) <u>87</u>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>  |  |
| 10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>   |  |
| 11. BIRTHPLACE (City and state or country) <u>SAVANNAH Mo</u>   |  |
| 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>   |  |
| 13a. FATHER'S NAME <u>John WALKER</u> 13b. MOTHER'S MAIDEN NAME <u>MARY Rhodus</u>  |  |
| 14. NAME OF HUSBAND OR WIFE <u>Mary HINES 3955 Adams K.C.K.</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>  |  |
| 16. SOCIAL SECURITY NO. <u>[redacted]</u> 17. INFORMANT <u>Mary Hines 3955 Adams K.C.K.</u>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Anemia - severe</u><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Uremia - advanced</u><br>DUE TO (c) <u>Arteriolar Nephrosclerosis - advanced</u> |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Generalized Arteriosclerosis - advanced.</u>   |  |
| PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 Month, Day, Year<br>a.m. p.m.  |  |
| 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>1-30-63</u> to <u>2-24-63</u> and last saw <sup>her</sup> / <sub>him</sub> alive on <u>2-24-63</u><br>Death occurred at <u>2:30 P.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.   |  |
| 22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>M.D.</u> 22b. ADDRESS <u>4320 Wornall Road, K.C.Mo.</u> 22c. DATE SIGNED <u>2-25-63.</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE <u>2-27-1963</u> 23c. NAME OF CEMETERY OR CREMATORY <u>FOSTER CEMETERY</u> 23d. LOCATION (City, town, or county) (State) <u>HARRISON County Missouri</u>  |  |
| 24. FUNERAL DIRECTOR <u>Noble Funeral Home</u> ADDRESS <u>New Hampton, Mo.</u> 25. DATE REC'D. BY LOCAL REG. <u>2-25-63</u> 26. REGISTRAR'S SIGNATURE <u>Ruth H. Long</u>   |  |

USE BLACK INK OR TYPEWRITER RIBBON

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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 Forrest D. Coldman

Licensed Embalmer No. 4714

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.