

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-006348

1405

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

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

FILED MAR 15 1963

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Rev. 4/59
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF Seibert G. Chennott, M.D. MEDICAL CERTIFICATION

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. 69 YRS.	c. CITY OR TOWN KANSAS CITY
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 118 EAST 72ND
3. NAME OF DECEASED (Type or print) First MIDDLE LAST Katherine M. Bodine		4. DATE OF DEATH Month Day Year MARCH 4 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 5-31-1875
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Self	11. BIRTHPLACE (City and state or country) PERRIERILL, OHIO
13a. FATHER'S NAME UNKNOWN		13b. MOTHER'S MAIDEN NAME LORINDA LIENHART	14. NAME OF HUSBAND OR WIFE Deceased
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		17. INFORMANT Address MRS. Lillian GREEN 118 E. 72nd	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO (b) Generalized Arterio sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Arterio sclerotic heart disease			INTERVAL BETWEEN ONSET AND DEATH 2 days yrs
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 3/3/63 to 3/4/63 and last saw her alive on 3/3/63 Death occurred at 4 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Seibert G. Chennott (Degree or title)		22b. ADDRESS #601 Independence Ave	22c. DATE SIGNED 3/4/63
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 3-6-1963	23c. NAME OF CEMETERY OR CREMATORY CALVARY	23d. LOCATION (City, town, or county) KANSAS CITY MO.
24. FUNERAL DIRECTOR Muehlebach		25. DATE RECD. BY LOCAL REG. 3-4-63	26. REGISTRAR'S SIGNATURE Ruth H Long
ADDRESS 6800 TROOST			

USE BLACK INK OR TYPEWRITER RIBBON

S. J. Chernoff - CH-1-5750

T.C. McHale -

4601 Independence

1:30 to 6:30 P.M.

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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