

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-006816

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 591

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

<b>FILED FEB 18 1963</b>		1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kansas City</u>		Length of stay in 1b <u>3 yrs.</u>		c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>General Hosp. (S.O.A.)</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>2920 E. 27th</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ernest</u>			First	Middle	Last
4. DATE OF DEATH <u>May 1 24 63</u>			Month	Day	Year
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1-24-60</u>	9. AGE (last birthday) <u>3 yrs.</u>	10. IF UNDER 1 YEAR Months
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Kansas City, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME <u>Betty J. May</u>		14. NAME OF HUSBAND OR WIFE <u>none</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of)			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Betty J. May</u> Address <u>2920 E. 27th K.C. Mo.</u>
18. CAUSE OF DEATH (Enter only one cause; per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Toxic Gastritis</u>			DUE TO (b) <u>History of ingestion of 4-way cold</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (c) <u>tablets &amp; chloroquin phosphate 250 or tablets</u>		
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 checked="" 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 <u>10:15</u> p.m. Month, Day, Year <u>1/24/63</u>		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.) <u>2920 E. 27</u>	
20f. CITY, TOWN, OR LOCATION <u>Kansas City, Jackson, Mo</u>		COUNTY		STATE	
21. I attended the deceased from _____ to _____ and last saw him/her alive on _____ Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>L.M. Tillman</u> (Degree or title) <u>M.D. Deputy Coroner</u>			22b. ADDRESS <u>1618 Lydia Ave.</u>		22c. DATE SIGNED <u>2/5/63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>1-30-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Cemetery</u>		23d. LOCATION (City, town, or county) <u>Kansas City, Mo.</u>
24. FUNERAL DIRECTOR <u>Mrs. C. E. Davis, K.C., Mo.</u>		ADDRESS		25. DATE RECD. BY LOCAL REG. <u>1-29-63</u>	26. REGISTRAR'S SIGNATURE <u>Oruth Song</u>

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF DOCUMENT

DATE AMENDED

VS 300 Rev. 4/59
1
23 378
3
4 2
5 0
6
7 0
8 1
9 8889
10 46
11 123
12 92-3
13

USE BLACK INK OR TYPEWRITER RIBBON

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

**STATEMENT BY LICENSED EMBALMER**

8-20

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 John R. Sidman  
Licensed Embalmer No. 4531  
P. O. Address Kansas City, 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.