

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-006847

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 861 STATE FILE NUMBER

FILED FEB 26 1963

VS 300 Rev. 4/59	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF	DOCUMENT
1			
2 3648			
3			
4 0			
5 1			
6			
7 0			
8 0			
9 4200			
10			
11			
12 90-0			
13			
ITEM NO.	SHOULD READ	MEDICAL CERTIFICATION	BY AFFIDAVIT OF

1. RACE 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 1b 15 years	c. CITY OR TOWN KANSAS CITY Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) 4035 Highland Avenue		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4035 Highland Avenue Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) 404 MILBURN MORTON			4. DATE OF DEATH Month February Day 7th Year 1963
5. SEX Male	6. COLOR OR RACE Caucasian	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12-3-04
9. AGE (last birthday) 56		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder		10b. KIND OF BUSINESS OR INDUSTRY Butler Mfg. Co	11. BIRTHPLACE (City and state or country) Fairplay Missouri
12. CITIZEN OF WHAT COUNTRY U.S.A.			
13a. FATHER'S NAME ROBERT MORTON		13b. MOTHER'S MARDEN NAME ESTHER BLAIR	
14. NAME OF HUSBAND OR WIFE Mrs Gladys Morton		17. INFORMANT Mrs Gladys Morton 4035 Highland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WORLD WAR II		16. SOCIAL SECURITY NO. [REDACTED]	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac dilatation			INTERVAL BETWEEN ONSET AND DEATH 15 min
DUE TO (b) Coronary thrombosis			24 hours
DUE TO (c) Arteriosclerotic heart disease			1 year +
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 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.	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 Brooklyn K.S., Mo.	
20g. COUNTY _____		20h. STATE _____	
21. I attended the deceased from 11-28-52 to 2-7-63 and last saw him alive on 2-6-63 Death occurred at 2:00 A. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Herbert Shuey M.D.		22b. ADDRESS 3903 Brooklyn K.S., Mo.	
22c. DATE SIGNED 2-8-63			
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE FEB 10 1963	23c. NAME OF CEMETERY OR CREMATORY BETHEL CEMETERY	23d. LOCATION (City, town, or county) (State) BETHEL MISSOURI
24. FUNERAL DIRECTOR D.W. NEWCOMER'S SONS KANSAS CITY Mo.		25. DATE RECD. BY LOCAL REG. 2-8-63	26. REGISTRAR'S SIGNATURE Ruth Long

USE BLACK INK OR TYPEWRITER RIBBON

Dr. Henderson, ¹⁶⁰⁰ Stacy H.D.
3903. Beesley Avenue
H. ...
2:00-5:00

10/1

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 W. Rowson

Licensed Embalmer No. 4889

P. O. Address Lithgow, 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.