

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-007121

DO NOT WRITE ON THIS STUD

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 967

STATE FILE NUMBER

FEB 26 1963

VS 300
Rev. 4/59

1
23398

3

4 2

5 1

6

7 1

8 0

9332X

10

11 286-0

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF
MEDICAL CERTIFICATION
John H. Wells

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		c. CITY OR TOWN Kansas City	
Length of stay in 1b 46 Yrs		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Elmwood Nursing Home 4600 E. 31st		d. STREET ADDRESS (If outside, give location) 2518 E. 25th	
3. NAME OF DECEASED (Type or print) Curtis Washington		4. DATE OF DEATH Month Day Year 2 10 63	
5. SEX Male	6. COLOR OR RACE Negro	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3-17-95
9. AGE (last birthday) 67		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self Employed		10b. KIND OF BUSINESS OR INDUSTRY Billard Room	
11. BIRTHPLACE (City and state or country) Desota Parrish, La.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Organ Washington		13b. MOTHER'S MAIDEN NAME Emma Adams	
14. NAME OF HUSBAND OR WIFE Dessie Washington		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) No None	
16. SOCIAL SECURITY NO. 49		17. INFORMANT Address Dessie Washington 2518 E. 25th	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis Generalized arteriosclerosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 30 days	
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 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 10 Jan 63 and last saw him alive on 9 Feb 63 Death occurred at 10:15 A m on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) John H Wells MD	
22b. ADDRESS 3718 Prospect		22c. DATE SIGNED 11 Feb 63	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2-16-63	23c. NAME OF CEMETERY OR CREMATORY Lincoln Cemetery	
23d. LOCATION (City, town, or county) K. C.		23e. STATE Mo/	
24. FUNERAL DIRECTOR ADDRESS Jones & Stevens 2315 Linwood		25. DATE RECD. BY LOCAL REG. 2-12-63	
26. REGISTRAR'S SIGNATURE P. Ruth Long			

USE BLACK INK OR TYPEWRITER RIBBON

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.