

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-011762

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary, Registration District No. 1002 Registrar's No. 1707

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB
AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

INSTEAD OF

DOCUMENT

FILED APR 1 1963

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City Length of stay in 1b 7 months
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION 4001 Warwick Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Jackson
c. CITY OR TOWN Kansas City Inside Limits Yes No
d. STREET ADDRESS (if outside, give location) 7027 Indiana Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Mary Middle Ann Last McCarty

4. DATE OF DEATH Month March Day 15 Year 1963

5. SEX Female 6. COLOR OR RACE White 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH 3-7-1874 9. AGE (last birthday) 89 IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HR

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Home 11. BIRTHPLACE (City and state or country) Virginia 12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME James Saunders 13b. MOTHER'S MAIDEN NAME Mary Weatherford 14. NAME OF HUSBAND OR WIFE Deceased

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes, give year or dates of service) No | None 16. SOCIAL SECURITY NO. [redacted] 17. INFORMANT Forest McCartney Address 2304 71 feet K.C. Mo

18. CAUSE OF DEATH (Enter only one cause per line)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CORONARY OCCLUSION
DUE TO (b) _____
DUE TO (c) _____
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) VARICOSE VEINS & ULCERATING

PART III. If deceased was female was there a pregnancy in last 90 days Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 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 NOT WHILE AT WORK 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 11-18-69 to 3-15-63 and last saw her alive on 3-15-63
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) [Signature] 22b. ADDRESS [Address] 22c. DATE SIGNED 3-16-63

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal 23b. DATE 3/17/1963 23c. NAME OF CEMETERY OR CREMATORY Blue Springs Cemetery 23d. LOCATION (City, town, or county) (State) Blue Springs Mo

24. FUNERAL DIRECTOR Webb Funeral Home - Blue Springs Mo ADDRESS _____ 25. DATE RECD. BY LOCAL REG. 3-16-63 26. REGISTRAR'S SIGNATURE [Signature]

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

BY AFFIDAVIT OF P. C. QUISBERT, MEDICAL CERTIFICATION

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 William Free

Licensed Embalmer No. 4733

P. O. Address Blue Springs 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.