

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-011819

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1517

<b>1. PLACE OF DEATH</b> a. COUNTY <u>JACKSON</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u> Length of stay in 1b <u>45 YEARS</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>DEAD ON ARRIVAL - RESEARCH HOSPITAL</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u> c. CITY OR TOWN <u>KANSAS CITY</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>2710 CHERRY STREET</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
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<b>3. NAME OF DECEASED</b> (Type or print) First <u>HAROLD</u> Middle <u>WALTER</u> Last <u>NIBLO</u>			<b>4. DATE OF DEATH</b> Month <u>MARCH</u> Day <u>6<sup>th</sup></u> Year <u>1963</u>				
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>CAUCASIAN</u>	<b>7. Married</b> <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>12/5/1905</u>	<b>9. AGE</b> (last birthday) <u>57</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>SHEET METAL WORKER</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>CORN PRODUCTS INC</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>MILAN, MISSOURI</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U. S. A.</u>	
<b>13a. FATHER'S NAME</b> <u>JAMES A. NIBLO</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>IDA MAY CADWELL</u>		<b>14. NAME OF HUSBAND OR WIFE</b> <u>MRS. LUCILE NIBLO</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <u>JAMES A. NIBLO</u> Address <u>935 E. 23<sup>RD</sup> AVENUE NORTH KANSAS CITY, MO.</u>		

**18. CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

**PART I. DEATH WAS CAUSED BY:**

IMMEDIATE CAUSE (a) Shock & hemorrhage resulting from ruptured esophageal varicose veins

DUE TO (b) embolus of liver

DUE TO (c) \_\_\_\_\_

**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.**  
 Yes  No  Unknown

<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)	
<b>20c. TIME OF INJURY</b> Hour _____ Month, Day, Year _____ a.m. _____ p.m.			
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	
<b>20f. CITY, TOWN, OR LOCATION</b>		<b>COUNTY</b>	
<b>STATE</b>			

21. I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_  
 Death occurred at 12:38 P. m on the date stated above, and to the best of my knowledge, from the causes stated.

<b>22a. SIGNATURE</b> (Degree or title) <u>Dr. C. Keith Long</u>		<b>22b. ADDRESS</b> <u>6627 Parkside Dr. S.W.</u>		<b>22c. DATE SIGNED</b> <u>3-6-63</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>REMOVAL</u>		<b>23b. DATE</b> <u>MAR. 9, 1963</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>OAKWOOD CEMETERY</u>	
<b>23d. LOCATION</b> (City, town, or county) (State) <u>MILAN MISSOURI</u>		<b>24. FUNERAL DIRECTOR</b> <u>D.W. NEWCOMER'S SONS, KANSAS CITY, MO.</u> ADDRESS <u>1331 BRUSH CREEK</u>			
<b>25. DATE RECD. BY LOCAL REG.</b> <u>3-8-63</u>			<b>26. REGISTRAR'S SIGNATURE</b> <u>C. Keith Long</u>		

VS 300 Rev. 4/59  
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AMENDED  
 DATE AMENDED  
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 DOCUMENT  
 BY AFFIDAVIT OF  
 C. Keith Long, M.D.  
 MEDICAL CERTIFICATION  
 SHOULD READ  
 ITEM NO.

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 Dean W. H. H.

Licensed Embalmer No. 4914

P. O. Address Indy, 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.