

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=63-015270

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 59 Primary Registration District No. _____ Registrar's No. 59

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED APR 30 1963

VS 300
Rev. 4/59

1 0190

2 3728

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4 1

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7 1

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9 X

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11 019

12 91-3

13 2-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

1. PLACE OF DEATH a. COUNTY <u>Cass</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Austin Twp.</u>		Length of stay in 1b <u>Instant</u>	c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>7 Miles S. Harrisonville</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>4746 Roanake Pkwy</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>KAREN KAE SHELTON</u>			4. DATE OF DEATH Month Day Year <u>April 26 1963</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9/25/1937</u>
9. AGE (last birthday) <u>25</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Buyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dept. Store</u>	11. BIRTHPLACE (City and state or country) <u>Salina, Kansas</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Kenneth Kiesel</u>	
13b. MOTHER'S MAIDEN NAME <u>Virginia Sweeney</u>		14. NAME OF HUSBAND OR WIFE <u>James Shelton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <u>Kenneth Kiesel</u>		Address <u>645 S. Santa Fe Salina, Kansas</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) <u>Broken Neck</u> DUE TO (b) <u>Car accident</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>Instant</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 type="checkbox"/> NO <input checked="" 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.) <u>Car accident</u>	
20c. TIME OF INJURY Hour <u>9:00</u> p.m. Month, Day, Year <u>4-27-63</u>	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>5 mi S. of Harrisonville</u>	20e. CITY, TOWN, OR LOCATION <u>Cass</u>	STATE <u>MO</u>
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Glenn Cummins</u>		22b. ADDRESS <u>Harrisonville, Mo.</u>	22c. DATE SIGNED <u>4-27-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>4/27/1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Salina Cemetery</u>
23d. LOCATION (City, town or county) <u>Salina, Kansas</u>		24. FUNERAL DIRECTOR <u>Atkinson Dickey, Harrisonville, Mo.</u>	
25. DATE RECD. BY LOCAL REG. <u>4-27-63</u>		26. REGISTRAR'S SIGNATURE <u>Ray J. Lebrun</u>	

USE BLACK INK OR TYPEWRITER RIBBON

SHOULD READ

BY AFFIDAVIT OF

MAY 2 1963

MAY 29 1963

JUN 4 1963

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 Robert C. Kinross

Licensed Embalmer No. 7902

P. Hessmiller, M.D.

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.

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