

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-016310

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2315

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED MAY 6 1963		1. PLACE OF DEATH a. COUNTY: <u>JACKSON</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) <u>KANSAS CITY</u>		Length of stay in 1b. <u>24 YEARS</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>St Joseph Hospital</u>		Inside Limits: Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location): <u>8420 Sni-A-Bar Road</u> Reside on Farm: Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CLARENCE O TOLEN</u>			4. DATE OF DEATH Month Day Year <u>APRIL 16 1963</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>CAUCASIAN</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>11-6-1912</u>	9. AGE (last birthday) <u>50</u>	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) <u>CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>POST OFFICE</u>		11. BIRTHPLACE (City and state or country): <u>LOCK SPRINGS, MO</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>		13a. FATHER'S NAME <u>CLARENCE O TOLEN</u>		13b. MOTHER'S MAIDEN NAME <u>ELIZABETH PARKER</u>	
14. NAME OF HUSBAND OR WIFE <u>NELLIE TOLEN</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES (WORLD WAR I)</u>		16. SOCIAL SECURITY NO. <u>[REDACTED]</u>	
17. INFORMANT <u>NELLIE TOLEN</u>		Address <u>8420 Sni-A-Bar Road</u>		18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 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)		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 SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 _____ to _____ and last saw her/him alive on _____. Death occurred at <u>11:30 P</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Hugh H. Owens Coroner</u>			22b. ADDRESS <u>152 Union Station</u>		22c. DATE SIGNED <u>4-17-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>APRIL 18, 1963</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FLORAL HILLS CEMETERY</u>	
23d. LOCATION (City, town, or county) <u>KANSAS CITY</u>		STATE <u>MISSOURI</u>		24. FUNERAL DIRECTOR <u>D.W. NEWCOMER'S SONS</u>	
ADDRESS <u>1331 Beulah Creek Blvd. Kansas City Mo</u>		25. DATE RECD. BY LOCAL REG. <u>4-17-63</u>		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

DOCUMENT

BY AFFIDAVIT OF H. Owens

MEDICAL CERTIFICATION

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DATE AMENDED

VS 300
Rev. 4/59.

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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 James W. Lawson

Licensed Embalmer No. 4889

P. O. Address Tabby, 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.

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