

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**=63-019949**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration-District No. 149 Primary Registration District No. 1002 Registrar's No. 2998

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF HIGH H. OWENS MEDICAL CERTIFICATION

USE BLACK INK OR TYPEWRITER RIBBON

**FILED JUN 7 1963**

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b> c. CITY OR TOWN <b>Kansas City North</b> d. STREET ADDRESS <b>4655 Antioch Road</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Kansas City</b>		Length of stay in 1b <b>61 yrs</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) <b>Trinity Lutheran Hospital</b>		d. STREET ADDRESS <b>4655 Antioch Road</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Grace May Barnes</b>			4. DATE OF DEATH Month <b>May</b> Day <b>25</b> Year <b>1963</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>5-1-1887</b>	9. AGE (last birthday) <b>76</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (City and state or country) <b>Ithaca, New York</b>	
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13a. FATHER'S NAME <b>John Stewart</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Geyser</b>	
14. NAME OF HUSBAND OR WIFE <b>Z. C. Barnes</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>[Redacted]</b>	
17. INFORMANT <b>Z. C. Barnes, 4655 Antioch Rd Kansas City</b>		18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple Rib fractures</b> DUE TO (b) <b>Hemothorax</b> DUE TO (c) <b>Auto accident</b>		INTERVAL BETWEEN ONSET AND DEATH	
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 checked="" type="checkbox"/> NO <input 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.) <b>Two car collision</b>			
20c. TIME OF INJURY Hour <b>5-19-63</b> Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				
20e. PLACE OF INJURY (e.g., at or about home, farm, factory, street, office bldg., etc.) <b>50 Highway Kansas City</b>		20f. CITY, TOWN, OR LOCATION <b>Jacobs md</b>		COUNTY STATE	
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>High H. Owens</b> (Degree or title)		22b. ADDRESS <b>152 Numer Station 5 763</b>		22c. DATE SIGNED <b>5-27-63</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>5-27-1963</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Floral Hills</b>	
23d. LOCATION (City, town, or county) <b>Kansas City, Missouri</b>		23e. LOCATION (City, town, or county) <b>Kansas City, Missouri</b>		23f. STATE <b>Missouri</b>	
24. FUNERAL DIRECTOR <b>Floral Hills Funeral Home</b> <b>Kansas City, Missouri</b>		25. DATE RECD. BY LOCAL REG. <b>5-27-63</b>		26. REGISTRAR'S SIGNATURE <b>Ruth Long</b>	

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**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 E. M. Johnson

Licensed Embalmer No. 3453

P. O. Address B. E. Kan.

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.