

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-019989

2571 STATE FILE NUMBER

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

FILED MAY 20 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 55 YEARS c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2603 AMIE COURT Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		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 <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) 2603 AMIE COURT Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First Middle Last ALICE MAHALIA CAMREN		4. DATE OF DEATH Month Day Year MAY 1, 1963	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8-19-1880
9. AGE (last birthday) 82		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY AT HOME
11. BIRTHPLACE (City and state or country) RICHMOND, MISSOURI		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13a. FATHER'S NAME WILLIAM PRIEST		13b. MOTHER'S MAIDEN NAME MAHALIA TEEGARDEN	
14. NAME OF HUSBAND OR WIFE FRED CAMREN		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO.		17. INFORMANT Address RALPH W. YOUNG 10802 E. 56th.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO (b) Hypertensive arteriosclerotic heart disease DUE TO (c) unknown Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH acute
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input 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.)	
20c. TIME OF INJURY Hour 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., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from <u>7/55</u> to <u>5/1/63</u> and last saw her <u>3/26/63</u> alive on Death occurred at <u>5:20 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>F. Van Buskirk MD</i>		22b. ADDRESS 5246 St. John KCMo	22c. DATE SIGNED 5/2/63
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 5-3-1963	23c. NAME OF CEMETERY OR CREMATORY MT. WASHINGTON CEMETERY
23d. LOCATION (City, town, or county) (State) INDEPENDENCE, MISSOURI		24. FUNERAL DIRECTOR ADDRESS C. H. BLACKMAN & SON INC. K. C., MO.	
25. DATE REC'D. BY LOCAL REG. 5-3-63		26. REGISTRAR'S SIGNATURE <i>Ruth Song</i>	

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

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF **F. Van Buskirk** MEDICAL CERTIFICATION

USE BLACK INK OR TYPEWRITER RIBBON

STATE OF MISSOURI
DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

STATE OF MISSOURI

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

STATE OF MISSOURI

DEPARTMENT OF HEALTH

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 Hubert B. Baird

Licensed Embalmer No. 4888

P. O. Address K 24, 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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