

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-020148

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2543 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

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF
H. B. OWENS
MEDICAL CERTIFICATION

FILED MAY 20 1963							
1. PLACE OF DEATH a. COUNTY <u>JACKSON</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u> Length of stay in <u>2 wks.</u> c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>540 HIGHLAND</u>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission): a. STATE <u>MO.</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>540 HIGHLAND</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>NEIL</u> Middle <u>JOHNSON</u> Last <u>JOHNSON</u>	4. DATE OF DEATH Month <u>4</u> Day <u>23</u> Year <u>63</u>						
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10-30-1892</u>	9. AGE (last birthday) <u>71</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>UNK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>UNK</u>		11. BIRTHPLACE (City and state or country) <u>OHIO</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>GEO. UNK</u>		13b. MOTHER'S MAIDEN NAME <u>UNK</u>		14. NAME OF HUSBAND OR WIFE _____			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT <u>JACKSON CO. CORONERS</u> Address _____			
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____						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 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 _____ 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 _____ on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Neil Johnson</u> (Degree or title) _____				22b. ADDRESS <u>152 Union Station</u>		22c. DATE SIGNED <u>4-27-63</u> (State) _____	
23a. BURIAL OR CREMATION (Specify) <u>burial</u>		23b. DATE <u>5-1-63</u>		23c. NAME OF CEMETERY OR CREMATORY <u>OSTEOPATHIC COLLEGE</u>		23d. LOCATION (City, town, or county) <u>R. C. MO.</u>	
24. FUNERAL DIRECTOR <u>H-TIGERMAN-SONN</u> ADDRESS <u>100 MO</u>		25. DATE RECD. BY LOCAL REG. <u>5-1-63</u>		26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>			

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 H. LeRoy Mooney

Licensed Embalmer No. 4776

P. O. Address H.P. Meier

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.