

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=63-020221

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2701 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
 William Bayne Allen MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Length of stay in 1b 53 yrs	c. CITY OR TOWN KANSAS CITY Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LUKES HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 48 East 55 St. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE F. MILLARD			4. DATE OF DEATH Month Day Year MAY 8, 1963
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12-2-1903
9. AGE (last birthday) 59		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) MDSE. SERVICE MGR.		10b. KIND OF BUSINESS OR INDUSTRY WESTERN AUTO	11. BIRTHPLACE (City and state or country) INDEPENDENCE, MO.
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME WILLIAM H. MILLARD	
13b. MOTHER'S MAIDEN NAME LOTTIE BELL		14. NAME OF HUSBAND OR WIFE VERNA MILLARD	
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. [REDACTED]	17. INFORMANT Address MRS. VERNA MILLARD 48 E. 55 St.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Artery Occlusion Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. Coronary atherosclerosis DUE TO (b) - DUE TO (c) -			INTERVAL BETWEEN ONSET AND DEATH 1 1/2 days
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 checked="" type="checkbox"/> NO <input 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 8/10/55 , to 5/8/63 and last saw him alive on 5/8/63 . Death occurred at 8:55 p m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE William Bayne Allen MD (Degree or title)		22b. ADDRESS 4620 J. Nichols St. Mo.	22c. DATE SIGNED 5/9/63 (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 5-11-1963	23c. NAME OF CEMETERY OR CREMATORY Mt. Washington	23d. LOCATION (City, town, or county) Kansas City, Missouri
24. FUNERAL DIRECTOR MUEHLEBACH ADDRESS 6800 Troost		25. DATE RECD. BY LOCAL REG. 5-9-63	26. REGISTRARS SIGNATURE Ruth Long

USE BLACK INK OR TYPEWRITER RIBBON

W. Allen
4600 P.C. - 7th St. - Perry
Dec 1 - 12.25 - 11
Sept 2.00 10 P - 0 -

pp.

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 L. Landes

Licensed Embalmer No. 5103

P. O. Address K.C. 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.