

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-020423

STATE FILE NUMBER

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 226

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

DATE AMENDED

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

<b>FILED MAY 21 1963</b>	
<p>1. PLACE OF DEATH a. COUNTY <u>Jackson</u></p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Independence</u> Length of stay in 1b <u>Hours</u></p> <p>c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Indep. San. &amp; Hosp.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clay</u></p> <p>c. CITY OR TOWN <u>Missouri City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) <u>Missouri City</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>
<p>3. NAME OF DECEASED (Type or print) First <u>ZINDA</u> Middle <u>DARLENE</u> Last <u>ELLIS</u></p>	<p>4. DATE OF DEATH Month <u>May</u> Day <u>9</u> Year <u>1963</u></p>
<p>5. SEX <u>Female</u></p>	<p>6. COLOR OR RACE <u>White</u></p>
<p>7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <u>5-8-1963</u></p>
<p>9. AGE (last birthday) <u>0</u> Months <u>0</u> Days <u>1</u></p>	<p>IF UNDER 1 YEAR IF UNDER 24 HR Hours Min.</p>
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u></p>	<p>10b. KIND OF BUSINESS OR INDUSTRY</p>
<p>11. BIRTHPLACE (City and state or country) <u>Independence, Mo.</u></p>	<p>12. CITIZEN OF WHAT COUNTRY <u>USA</u></p>
<p>13a. FATHER'S NAME <u>Fred Ellis</u></p>	<p>13b. MOTHER'S MAIDEN NAME <u>Linda Robb</u></p>
<p>14. NAME OF HUSBAND OR WIFE <u>none</u></p>	
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u></p>	<p>16. SOCIAL SECURITY NO. <u>[redacted]</u></p>
<p>17. INFORMANT Address <u>Fred Ellis, Liberty, Mo.</u></p>	
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <u>Circulatory Collapse</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u></p> <p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Bilateral adrenal hemorrhage</u> <u>12 hours</u></p> <p>DUE TO (c)</p>	
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Neonatal apnea</u></p>	
<p>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</p>	
<p>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	<p>20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/></p>
<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)</p>	
<p>20c. TIME OF INJURY Hour <u>3</u> a.m. <u>pm</u> Month, Day, Year <u>5-8-63</u></p>	
<p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p>	<p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>
<p>20f. CITY, TOWN, OR LOCATION <u>Liberty</u> COUNTY <u>Clay</u> STATE <u>Mo.</u></p>	
<p>21. I attended the deceased from <u>1 pm 5-8-63</u> to <u>5-9-63</u> and last saw her alive on <u>5-9-63</u> Death occurred at <u>3 pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.</p>	
<p>22a. SIGNATURE (Degree or title) <u>Charles E. Jones M.D.</u></p>	<p>22b. ADDRESS <u>Indep. Mo</u></p>
<p>22c. DATE SIGNED <u>5-13-63</u></p>	
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></p>	<p>23b. DATE <u>5-14-1963</u></p>
<p>23c. NAME OF CEMETERY OR CREMATORY <u>Fairview Cemetery</u></p>	<p>23d. LOCATION (City, town, or county) (State) <u>Liberty Clay Mo.</u></p>
<p>24. FUNERAL DIRECTOR ADDRESS <u>Dasley Funeral Home, Liberty, Mo.</u></p>	<p>25. DATE RECD. BY LOCAL REG. <u>5-14-63</u></p>
<p>26. REGISTRAR'S SIGNATURE <u>Alba P. Crang</u></p>	

USE BLACK INK OR TYPEWRITER RIBBON

5:14.53

**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 John Pasley

Licensed Embalmer No. 4308

P. O. Address Liberty, 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.