

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-020424

Registration District No. 746

Primary Registration District No. 3026

Registrar's No. 257

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

**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> COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Independence</b>		c. CITY OR TOWN <b>Kansas City</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Indep. Sanit. &amp; Hosp.</b>		d. STREET ADDRESS <b>240 North Glenwood</b> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HOMER</b> Middle <b>THEODORE</b> Last <b>FOLKERT</b>		4. DATE OF DEATH Month <b>June</b> Day <b>2</b> Year <b>1963</b>	
5. SEX <b>male</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>June 6, 1912</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Floor Sander</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Floor Service</b>	11. BIRTHPLACE (City and state or country) <b>Sedalia, Mo.</b>
13a. FATHER'S NAME <b>Claude Newcomb</b>		13b. MOTHER'S MAIDEN NAME <b>Margaret Busker</b>	14. NAME OF HUSBAND OR WIFE <b>Martha Thelma Folkert</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>None</b>	
17. INFORMANT <b>Martha Thelma Folkert-240 N. Glenwood</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO (b) <b>Arteriosclerotic vascular disease</b> DUE TO (c) <b>Bundle branch block.</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			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) <b>Arterial hypertension</b>			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 checked="" 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 alive on <b>May 23, 1963</b> Death occurred at _____ m on the date stated above, and to the best of my knowledge from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Chas. Nelson J. M.D.</b>		22b. ADDRESS	22c. DATE SIGNED <b>6/4/63</b> (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>June 5, 1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Floral Hills Cem.</b>	23d. LOCATION (City, town, or county) <b>Kansas City, Missouri</b>
24. FUNERAL DIRECTOR <b>Geo. C. Carson &amp; Sons-Indep. Missouri</b>		25. DATE RECD. BY LOCAL REG. <b>6-4-63</b>	26. REGISTRAR'S SIGNATURE <b>Alba L. Craig</b>

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300 Rev. 4/59

17005

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USE BLACK INK OR TYPEWRITER RIBBON

108-108-108

RECEIVED

JAN 23 1964

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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 Kenneth R. Lamman

Licensed Embalmer No. 5207

P. O. Address Indiantown, 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.