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## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 73Primary Registration District No. 5291Registrar's No. 71FILE NO. 63-028839

FILED JUN 25 1963

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Rev. 4/591 60032 6003

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
INSTEAD OF

SHOULD READ

ITEM NO.

USE BLACK INK  
OR  
TYPEWRITER RIBBON

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Clay</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clay</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>R.R.1, Liberty</u>		Length of stay in 1b <u>5 YEARS</u>	c. CITY OR TOWN <u>Liberty</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1 mile E. of Liberty, Mo</u>		Inside Limits: Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1 mile E. of Liberty</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>John Clarence Gaines</u>			4. DATE OF DEATH Month Day Year <u>June 13, 1963</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2/15/1887</u>
9. AGE (last birthday) <u>76</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>Cutter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Manufacturing</u>	11. BIRTHPLACE (City and state or country) <u>Clay County, Missouri</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>John Gaines</u>	
13b. MOTHER'S MAIDEN NAME <u>Rebecca Holt</u>		14. NAME OF HUSBAND OR WIFE <u>Bessie Hightower</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <u>No</u>		16. SOCIAL SECURITY NO. <u>[REDACTED]</u>	17. INFORMANT Address <u>Bessie Gaines, R.R. #1, Liberty, Mo</u>
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>6 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetic neuropathy, severe.</u> <u>Metabolic Mellitus, severe.</u>			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 s.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 <u>Liberty, Mo.</u>	COUNTY STATE
21. I attended the deceased from <u>1917</u> , to <u>1963</u> and last saw her/him alive on <u>June 12, 1963</u> Death occurred at <u>7:30 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>R. B. Bowles, md.</u>		22b. ADDRESS <u>Liberty, Mo.</u>	22c. DATE SIGNED <u>6-17-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>6/15/1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Crown Hill</u>	23d. LOCATION (City, town, or county) (State) <u>Excelsior Springs, Mo</u>
24. FUNERAL HOME, ADDRESS <u>Excelsior Springs, Missouri</u>		25. DATE RECD. BY LOCAL REG. <u>6-20-63</u>	26. REGISTRAR'S SIGNATURE <u>Mabel Graham</u>

(Licensed Embalmer's Statement on Reverse Side)

JUL 29 1963

**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

*Leidey Jarman*

Licensed Embalmer No.

*4589*

P. O. Address

*Excelsior Springs, 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.