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MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-023654

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 77 Primary Registration District No. 3013 Registrar's No. 142

FILED JUN 17 1963

VS 300
Rev. 4/59

1 6004

2 6004

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4 1

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9 570.2

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12 6-0

13 2-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

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>North Kansas City</u>		c. CITY OR TOWN <u>North Kansas City</u>	
Length of stay in 1b		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>North Kansas City Memorial Hosp</u>		d. STREET ADDRESS (If outside, give location) <u>30th + Swift</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>C</u> Last <u>Moore</u>			4. DATE OF DEATH Month <u>6</u> Day <u>12</u> Year <u>63</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>Cauc.</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>10-14-77</u>
9. AGE (last birthday) <u>85</u>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>
11. BIRTHPLACE (City and state or country) <u>Johnson County, Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>SAMUEL A. HOWE</u>		13b. MOTHER'S MAIDEN NAME <u>SUSAN HORNSBY</u>	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		15. INFORMANT <u>MRS. G.F. MONTGOMERY, No. Kansas City, Mo.</u>	
16. SOCIAL SECURITY NO.		17. ADDRESS <u>Address</u>	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Toxemia</u> DUE TO (b) <u>Obstruction small bowel and ileus</u> DUE TO (c) <u>Mesenteric venous thrombosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Generalized arteriosclerosis toxic hepatitis?</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 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 <u>PATHOLOGIST</u> to <u>FOR ATTENDING</u> and last saw her/him alive on <u>PHYSICIAN</u> <u>ROBERT H. HODGE M.D.</u> <u>9:40 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>W.P. McPhee M.D.</u>		22b. ADDRESS <u>2029 BURLINGTON ST. N.K.C. Mo.</u>	
22c. DATE SIGNED <u>6-12-63</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>June 14, 1963</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Holden Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Holden, Mo.</u>	
24. FUNERAL DIRECTOR <u>CAST FUNERAL HOME</u> ADDRESS <u>HOLDEN, MO.</u>		25. DATE RECD. BY LOCAL REG. <u>6-13-63</u>	
26. REGISTRAR'S SIGNATURE <u>Marguerite Hudgens</u>			

(Licensed Embalmer's Statement on Reverse Side)

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 *EBC*

Licensed Embalmer No. 4059

P. O. Address Holden, 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.