

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

3495 **63-024418**
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

DO NOT WRITE ON THIS STUB

AMENDED

FILED JUL 5 1963

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>ILLINOIS</u> b. COUNTY <u>SANGAMON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP, only) OR TOWN <u>KANSAS CITY</u>		Length of stay in 1b <u>6 days</u>	c. CITY OR TOWN <u>SPRINGFIELD</u> 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>ST. LUKE'S HOSPITAL</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>629 NORTH 5TH STREET</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>LENA</u> Middle <u>HAZEL</u> Last <u>JONES</u>			4. DATE OF DEATH Month <u>JUNE</u> Day <u>21</u> Year <u>1963</u>
5. SEX <u>FEMALE</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>4/27/1894</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY -----	9. AGE (last birthday) <u>69</u> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HR: Hours _____ Min. _____
11a. FATHER'S NAME <u>UNKNOWN</u>		11b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	11. BIRTHPLACE (City and state or country) <u>SHELBYVILLE, ILLINOIS</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. -----	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>UNKNOWN</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	14. NAME OF HUSBAND OR-WIFE <u>A. C. JONES</u> Address <u>629 NORTH 5TH STREET SPRINGFIELD ILLINOIS</u>
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bleeding Esophageal Varices</u> DUE TO (b) <u>Cirrhosis of Liver</u> DUE TO (c) <u>Post necrotic Scarring ?</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>?</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>None</u>			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 <u>6-16-63</u> to <u>6-21-63</u> and last saw her/him alive on <u>6-21-63</u> Death occurred at <u>8:10 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Morgan U. Stockwell M.D.</u>		22b. ADDRESS <u>2500 Johnson Dr. S.M. Kans.</u>	22c. DATE SIGNED <u>6-22-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>JUNE 22 1963</u>	23c. NAME OF CEMETERY OR-CREMATORY <u>OAK RIDGE CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>SPRINGFIELD ILLINOIS</u>
24. FUNERAL DIRECTOR <u>D.W. NEWCOMER'S SONS, 1331 BRUSH CREEK, KANSAS CITY, MO.</u>		25. DATE RECD. BY LOCAL REG. <u>6-22-63</u>	26. REGISTRAR'S SIGNATURE <u>North Long</u>

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

BY AFFIDAVIT OF NOT CAR U. STOCKWELL MEDICAL CERTIFICATION

USE BLACK INK OR TYPEWRITER RIBBON

Dr. Morgan U. Blackwell
2500 Johnson Drive, Madison, Kansas
11-30-4

11-30-4
11-30-4
11-30-4

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,

signed by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Louis Gust*

Licensed Embalmer No. 4096

P. O. Address M. 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.