

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH.

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-024487

Registration District No. 149 Primary Registration District No. 1022 Registrar's No. 3189 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS-300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF K. J. Shireman MEDICAL CERTIFICATION

USE BLACK INK OR TYPEWRITER RIBBON

FILED JUN 17 1963		1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in lb 37 yrs.		c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Northeast Nursing Home		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 6606 East 9th Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WALTER Middle J. Last MENTER			4. DATE OF DEATH Month June Day 4 Year 1963		
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10-29-1877	9. AGE (last birthday) 85	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Sheffield Steel		11. BIRTHPLACE (City and state or country) Port Washington, Wis.	
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME John Menter		13b. MOTHER'S MAIDEN NAME Melissa J ean Bates	
14. NAME OF HUSBAND OR WIFE Nora Susan Menter - De		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 		17. INFORMANT Address James Menter, 6606 E. 9th, K.C. Mo.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Thrombosis DUE TO (b) Coronary Artery Arteriosclerosis DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH 2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____					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 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 Kansas City, Jackson Mo.		
21. I attended the deceased from Jan 1962 to June 1963 and last saw him alive on June 2, 1963 . Death occurred at 5:15 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) K. J. Shireman M.D.			22b. ADDRESS 4606 St John K.C. Mo.		22c. DATE SIGNED 6-5-63
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 6-7-1963	23c. NAME OF CEMETERY OR CREMATORY Mount Washington		23d. LOCATION (City, town, or county) (State) Independence, Mo.	
24. FUNERAL DIRECTOR ADDRESS Sheil Funeral Home, Kansas City, Mo.			25. DATE RECD. BY LOCAL REG. 6-5-63	26. REGISTRAR'S SIGNATURE Ruth Long	

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

Jimmy S. Birch

Licensed Embalmer No. 5212

P. O. Address K-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.

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