

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH.

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-024523

3113

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3113

FILED JUN 17 1963

DO NOT WRITE ON THIS STUB

AMENDED

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Length of stay in 1b 5 yrs.	c. CITY OR TOWN KANSAS CITY Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION V A HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 3215 CAMPBELL Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last OLIVER O'CONNOR			4. DATE OF DEATH Month Day Year May 28, 1963
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7-6-86
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired laborer		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) 76 IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
11a. BIRTHPLACE (City and state or country) Albia, Iowa		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Moses O'Connor		13b. MOTHER'S MAIDEN NAME Martha Bruce	
14. NAME OF HUSBAND OR WIFE ---		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) Yes WWI	
16. SOCIAL SECURITY NO.		17. INFORMANT VA Hospital Official Records, K.C. Mo 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) Cerebrovascular disease several yrs.			
DUE TO (b) Arteriosclerosis, generalized			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) wound infection, diabetes mellitus Fracture of left hip with operative			
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 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 Month, Day, Year a.m. p.m.			
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. VA attended the deceased from Feb. 26, 1963 to May 28, 1963 Death occurred at 9:12 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>[Signature]</i> (Degree or title) TANK ZIMMERMAN M.D.		22b. ADDRESS VA Hospital, Kansas City, Mo.	22c. DATE SIGNED 5-29-63
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE JUNE 3, 1963	23c. NAME OF CEMETERY OR CREMATORY NATIONAL CEMETERY	23d. LOCATION (City, town, or county) (State) FORT LEAVENWORTH KANSAS
24. FUNERAL DIRECTOR D.W. NEWCOMER'S SONS	ADDRESS 1331 BRUSH CREEK KANSAS CITY, MO.	25. DATE RECD. BY LOCAL REG. 6-1-63	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>

USE BLACK INK OR TYPEWRITER RIBBON

STATE

DEPARTMENT OF HEALTH

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STATE OF MISSOURI

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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 Robert A. Sawyer

Licensed Embalmer No. 4892

P. O. Address Overland Park, KS

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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