

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-024705

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUD

AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 279 STATE FILE NUMBER

FILED JUN 20 1963

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>JACKSON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>INDEPENDENCE</u> Length of stay in 1b <u>14 10 mo.</u>		c. CITY OR TOWN <u>BLUE SPRINGS.</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>CABLE REST HOME</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>702 20 18TH</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>HAROLD. BAUGHMAN</u>			4. DATE OF DEATH Month Day Year <u>6 15 63</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug-16-77</u>
9. AGE (last birthday) <u>85</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>	11. BIRTHPLACE (City and state or country) <u>Dunlap Iowa</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>
13a. FATHER'S NAME <u>Hegeshial Baughman</u>		13b. MOTHER'S MAIDEN NAME <u>Irene Miller</u>	14. NAME OF HUSBAND OR WIFE <u>Deceased</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. <u>[REDACTED]</u>	17. INFORMANT Address <u>Myron Allen Blue Springs Mo</u>
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>Coronary Artery Occlusion</u> DUE TO (c) <u>Coronary Atherosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u> <u>3 hrs</u>
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 checked="" 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>8-14-61</u> to <u>6-13-63</u> and last saw ^{her} him alive on <u>6-13-1963</u> Death occurred at <u>9:12 pm.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Robert Weaver MD</u>		22b. ADDRESS <u>Independence, Mo</u>	
22c. DATE SIGNED <u>6/16/63</u>		22d. LOCATION (City, town, or county) (State) <u>Crawford Iowa</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>6-16-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Dow City</u>	
24. FUNERAL DIRECTOR <u>Mayfield</u> ADDRESS <u>Blue Springs Mo</u>		25. DATE RECD. BY LOCAL REG. <u>6-16-63</u>	26. REGISTRAR'S SIGNATURE <u>Alba L. Gray</u>

(Licensed Embelmer's Statement on Reverse Side)

JUN 25 1963

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1000
1000
6-11-63
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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 Charles E. Mayfield

Licensed Embalmer No. 4638

P. O. Address Blue Springs

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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