

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-027393
STATE FILE NUMBER

042

1000

883

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

FILED JUL 24 1963

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION
C. Smith, M.D.

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

USE BLACK INK
OR
TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in 1b 8 months	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 State Hospital #2		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS 309 Forest (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) Karl Frank Weber			4. DATE OF DEATH Month July Day 20 Year 1963		
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5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH 12/26/02	9. AGE (last birthday) 61	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of year) Printing Business	10b. KIND OF BUSINESS OR INDUSTRY for self	11. BIRTHPLACE (City and state or country) Kansas City, Mo	12. CITIZEN OF WHAT COUNTRY U.S.
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13a. FATHER'S NAME Joseph Weber	13b. MOTHER'S MAIDEN NAME Rose Colbourn	14. NAME OF HUSBAND OR WIFE Divorced
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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. yes ???	17. INFORMANT Address Records State Hospital #2.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	General Peritonitis 2 days	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	Ruptured Appendix 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
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year _____
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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
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21. I attended the deceased from 11/12/62 to 7/20/63 and last saw her alive on 7/20/63 Death occurred at 10:08 P. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Date of issue) C. Smith M.D.	22b. ADDRESS State Hospital #2	22c. DATE SIGNED 7/20/63.
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE July 21, 1963	23c. NAME OF CEMETERY OR CREMATORY D. W. Newcomer's Sons	23d. LOCATION (City, town, or county) (State) Kansas City, Missouri
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24. FUNERAL DIRECTOR ADDRESS Malerhoffer-Fleeman Inc., St. Joseph, Mo.	25. DATE RECD. BY LOCAL REG. July 22, 1963	26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell
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Permit renewed 7-21-63

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 Albert R. Harrington

Licensed Embalmer No. 3258

P. O. Address St. Joseph, 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.