

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-028197

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4060 STATE FILE NUMBER

**FILED AUG 6 1963**

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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

BY AFFIDAVIT OF **Frank S. Hogue** MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Platte</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <b>Town Kansas City</b>		Length of stay in lb <b>55 days</b>	c. CITY OR TOWN <b>Camden Point</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Children's Mercy Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>Rural Route</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Theresa</b> Middle <b>Ann</b> Last <b>Bywaters</b>			4. DATE OF DEATH Month <b>7</b> Day <b>18</b> Year <b>63</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>1-12-65</b>
9. AGE (last birthday) <b>12 years</b>		IF UNDER 1 YEAR Months _____ Days _____ Hours _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>Child</b>	11. BIRTHPLACE (City and state or country) <b>Jamesport, Missouri</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME <b>William Gordon Bywaters</b>	
13b. MOTHER'S MAIDEN NAME <b>Dixie Barnett</b>		14. NAME OF HUSBAND OR WIFE <b>—</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of)		16. SOCIAL SECURITY NO.	17. INFORMANT <b>Father</b> Address <b>Same</b>
18. CAUSE OF DEATH (Enter only one cause of death) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Renal Failure</b> DUE TO (c) <b>glomerulonephritis</b>			INTERVAL BETWEEN ONSET AND DEATH
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 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 <b>5-23-63</b> to <b>7-18-63</b> and last saw her alive on <b>7-18-63</b> Death occurred at <b>10:40 A.M.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Frank S. Hogue, M.D.</b> (Degree or title)		22b. ADDRESS <b>H390 Wornall Rd. N. City</b>	22c. DATE SIGNED <b>7-18-63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>7-20-63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CAMDEN POINT CEM.</b>	23d. LOCATION (City, town, or county) (State) <b>CAMDEN POINT, MO</b>
24. FUNERAL DIRECTOR <b>VAUGHAN-AUFRANC</b>		25. DATE RECD. BY LOCAL REG. <b>7-19-63</b>	26. REGISTRAR'S SIGNATURE <b>Ruth Song</b>

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK OR TYPEWRITER RIBBON

**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 W. R. Vaughn

Licensed Embalmer No. X023

P. O. Address Weston, 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.