

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**163-028226**

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4227 STATE FILE NUMBER

**FILED AUG 14 1963**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>JACKSON</b> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b> Length of stay in 1b <b>1 day</b> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. JOSEPH HOSPITAL</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b> c. CITY OR TOWN <b>INDEPENDENCE</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <b>10314 East 35th St.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
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<b>3. NAME OF DECEASED</b> First Middle Last <b>LILLIE COMBS</b>			<b>4. DATE OF DEATH</b> Month Day Year <b>JULY 28, 1963</b>			
<b>5. SEX</b> <b>FEMALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. Married</b> <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>7-19-1881</b>	<b>9. AGE</b> (last birthday) <b>82</b>	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	<b>IF UNDER 24 HR</b> Hours Min.

<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>TAILOR</b>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>CLEANING SHOP</b>	<b>11. BIRTHPLACE</b> (City and state or country) <b>KANSAS CITY, MO.</b>	<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A.</b>
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<b>13a. FATHER'S NAME</b> <b>JOHN BEEBE</b>	<b>13b. MOTHER'S MAIDEN NAME</b> <b>ROSA INGLEMAN</b>	<b>14. NAME OF HUSBAND OR WIFE</b> <b>CRAIG COMBS - Dec'd.</b>
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<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) NO NO	<b>17. INFORMANT</b> Address <b>Mrs. Geraldine Bly, 10314 E. 35th St., Mo. Indep.</b>
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<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Failure</u> DUE TO (b) <u>Cardiac Dilatation</u> DUE TO (c) <u>Myocardial Degeneration</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u> <u>2 yrs</u> <u>2 yrs</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Atherosclerosis</u>	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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<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT SUICIDE HOMICIDE</b> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)
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<b>20c. TIME OF INJURY</b> Hour - Month, Day, Year a.m. p.m.	<b>20d. INJURY OCCURRED</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>
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<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE <b>INDEPENDENCE, MISSOURI</b>
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<b>21. I attended the deceased from</b> <u>Jan 1960</u> to <u>present</u> and last saw her/him alive on <u>7-27-63</u> Death occurred at <u>7 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.	<b>22c. DATE SIGNED</b> <b>7-29-63</b>
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<b>22a. SIGNATURE</b> (Degree or title) <u>George K. Boyd MD</u>	<b>22b. ADDRESS</b> <u>5111 Independence Ave</u>	<b>22c. DATE SIGNED</b> <b>7-29-63</b>
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<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>BURIAL</b>	<b>23b. DATE</b> <b>7-30-63</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>MT. WASHINGTON CEMETERY</b>	<b>23d. LOCATION</b> (City, town, or county) (State) <b>INDEPENDENCE, MISSOURI</b>
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<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>GEO. C. CARSON &amp; SONS, INDEPENDENCE, MO.</b>	<b>25. DATE RECD. BY LOCAL REG.</b> <b>7-29-63</b>	<b>26. REGISTRAR'S SIGNATURE</b> <u>Arth Long</u>
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(Licensed Embalmer's Statement on Reverse Side)

DO NOT WRITE ON THIS STUB

AMENDED

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF George K. Boyd

MEDICAL CERTIFICATION

USE BLACK INK OR TYPEWRITER RIBBON

VS 300 Rev. 4/59

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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 J. T. Crowell

Licensed Embalmer No. 4904

P. O. Address J. T. Crowell

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.