

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-028253
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4134

FILED AUG 9 1963

DO NOT WRITE ON THIS STUB

AMENDED

1. PLACE OF DEATH a. COUNTY <u>Jackson</u> b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kansas City</u> Length of stay in lb <u>20 mo.</u> c. FULL NAME OF (if NOT in hospital, give location) <u>Home Gladestone Nurseing</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Kansas</u> b. COUNTY <u>Crawford</u> c. CITY OR TOWN <u>Franklin</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>Home Gladestone Nurseing</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
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3. NAME OF DECEASED First <u>Mary</u> Middle <u>Debelak</u> Last <u>Debelak</u> (Type or print)			4. DATE OF DEATH Month <u>July</u> Day <u>23</u> Year <u>1963</u>		
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5. SEX <u>Female</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>Nov. 8, 1872</u>	9. AGE (last birthday) <u>90</u>	10. IF UNDER 1 YEAR Months _____ Days _____	11. IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (City and state or country) <u>Austria</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>Frank Napotneck</u>	13b. MOTHER'S MAIDEN NAME <u>Unkown</u>	14. NAME OF HUSBAND OR WIFE <u>Frank Debelak</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) <u>NO</u>	16. SOCIAL SECURITY NO. _____	17. INFORMANT Address <u>Mrs. Mary McDonald Kansas City Mo.</u>
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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>Arterio sclerotic Heart Disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>years</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)	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 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.)
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20c. TIME OF INJURY Hour _____ 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
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21. I attended the deceased from Aug. 2 - 1961 to 7-23-63 and last saw her alive on Jan. 16 - 1963
 Death occurred at 7:00 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>M. G. Cline M.D.</u>	22b. ADDRESS <u>4126 St. John KC23, MO</u>	22c. DATE SIGNED <u>7-23-63</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>July 23, 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Highland Park</u>	23d. LOCATION (City, town, or county) (State) <u>Pittsburg Kansas</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Hoge Funeral Home Overland Park Kansas</u>	25. DATE RECD. BY LOCAL REG. <u>7-23-63</u>	26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>
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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION BY AFFIDAVIT OF M. G. Cline

USE BLACK INK OR TYPEWRITER RIBBON

4176 *[Handwritten]*

OCT 22 1963

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. Royce Hoyle*

Licensed Embalmer No. 3579

P. O. Address *Oakland Park Kan*

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: