

# MISSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-028259  
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3961

**FILED AUG 6 1963**

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

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9420.1

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

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>JACKSON</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		c. CITY OR TOWN <b>KANSAS CITY</b>	
Length of stay in 1b <b>life</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>V A HOSPITAL</b>		d. STREET ADDRESS (If outside, give location) <b>2625 KENSINGTON</b>	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>EIMER</b> Middle <b>E</b> Last <b>DOBSON</b>			4. DATE OF DEATH Month <b>July</b> Day <b>12</b> Year <b>1963</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>10-4-96</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Radio electrician, retired</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) <b>66</b>
11. BIRTHPLACE (City and state or country) <b>Kansas City, Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Joseph Dobson</b>		13b. MOTHER'S MAIDEN NAME <b>Mary J. Sypris</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 service) <b>Yes WWI</b>		16. SOCIAL SECURITY NO. <b>VA Hospital Official Records, K.C. Mo</b>	
17. INFORMANT <b>VA Hospital Official Records, K.C. Mo</b>			Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Recent myocardial infarction</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1-2 days</b>
DUE TO (b) <b>Atherosclerosis of coronary arteries</b>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Arterioloephrosclerosis, hypertension, cardiac hypertrophy</b>			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 <b>---</b> Month, Day, Year <b>---</b> a.m. <b>---</b> p.m. <b>---</b>	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>June 25, 1963</b> to <b>July 12, 1963</b> Death occurred at <b>12:30</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>JAMES M. FLYNN M.D.</b>		22b. ADDRESS <b>VA Hospital, Kansas City, Mo.</b>	
22c. DATE SIGNED <b>7-12-63</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>7-15-1963</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn Cemetery</b>		23d. LOCATION (City, town, or county) <b>Kansas City, Missouri</b>	
24. FUNERAL DIRECTOR <b>Muehlebach</b>		25. DATE RECD. BY LOCAL REG. <b>7-15-63</b>	
26. REGISTER'S SIGNATURE <b>P. Ruth Long</b>			

USE BLACK INK OR TYPEWRITER RIBBON

NOCTAR

ILLUSTRATION

NOCTAR

WITNESSES

NAME

WITNESSES

RESIDENCE

NO.

JAMESON A V

DATE, TIME

TIME

NO.

NAME

NO.

DATE

NO.

NAME

NO.

A.B.N.

RESIDENCE

RESIDENCE

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ADDRESS

ADDRESS

OF THE ABOVE DESCRIBED PERSON

NAME

DATE

RESIDENCE

**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

*Robert G. Landes*

Licensed Embalmer No. 5103

P. O. Address H.C. No

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.