

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

68-028830

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 746 Primary Registration District No. 3026 Registrar's No. 363
FILED AUG 6 1963

STATE FILE NUMBER

VS 300 Rev. 4/59	DATE AMENDED
17005	
28150	
3	
4 0	
5 1	
6	
7 1	
8 0	
9 X	
10	
11700	
122-3	
13 1-0	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>KANS.</u> b. COUNTY _____	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>INDEP. MO</u> Length of stay in 1b _____		c. CITY OR TOWN <u>WICHITA</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>D.O.A. INDEP. HOSP.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>3144 JEANETTE</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES O MC DANIEL</u>			4. DATE OF DEATH Month Day Year <u>7 31 - 63</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1-6-15</u>
9. AGE (last birthday) <u>48</u>		IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HR Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRUCK DRIVER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PUNDEE TEXAS</u>	12. CITIZEN OF WHAT COUNTRY <u>US</u>
13a. FATHER'S NAME <u>J.A. MC DANIEL</u>		13b. MOTHER'S MAIDEN NAME <u>RUBY BOWDEN</u>	
14. NAME OF HUSBAND OR WIFE <u>Bonnie Mc Daniel</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or date of service) <u>Yes WW # 2</u>	
16. SOCIAL SECURITY NO. _____		17. INFORMANT Address <u>Wichita, Kas</u> <u>Mrs Bonnie Mc Daniel</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushed Chest Fr Top Ribs</u> DUE TO (b) <u>Fr L femur numerous</u> DUE TO (c) <u>lacerations whole body</u>			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 <u>nitroglycerin & Insultion</u>			PART III. If deceased was female was there a pregnancy in last 90 days. <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>Two Car Transport Collision</u>	
20c. TIME OF INJURY Hour a.m. p.m. <u>7:31 63</u> Month, Day, Year <u>7 31 63</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Highway</u>		
20f. CITY, TOWN OR LOCATION <u>Oak Grove Jackson</u> COUNTY <u>MO</u> STATE <u>MO</u>		21. I attended the deceased from _____ to _____ and last saw him alive on _____ Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>Arthur A Owens Coroner</u>		22b. ADDRESS <u>152 main station</u>	22c. DATE SIGNED <u>7 31 63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removed</u>	23b. DATE <u>8-1-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Jasper</u>	23d. LOCATION (City, town, or county) <u>Harrison Ark</u>
24. FUNERAL DIRECTOR <u>Mayfield Blue Springs</u> ADDRESS <u>Blue Springs</u>		25. DATE RECD. BY LOCAL REG. <u>8-1-63</u>	26. REGISTRAR'S SIGNATURE <u>Alva & Craig</u>

AUG 16 1963

AUG 14 1963

AUG 30 1963

2002
8120

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-801/
6-20-63

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 Charles E Mayfield

Licensed Embalmer No. 4638

P. O. Address Blue Springs,

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.