

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 799 Primary Registration District No. 1005 Registrar's No. 43463-032349 STATE FILE NUMBER

FILED AUG 20 1963							
1. PLACE OF DEATH a. COUNTY JACKSON b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY Length of stay in 1b 2 1/2 YRS. c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DOCTORS HOSPITAL Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON c. CITY OR TOWN KANSAS CITY Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) 4828 PARK Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last JAMES BRADFORD MC ELHINNY							
4. DATE OF DEATH Month Day Year AUGUST 1, 1963							
5. SEX MALE	6. COLOR OR RACE WHITE						
7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11-16-85 9. AGE (last birthday) 77						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN							
10b. KIND OF BUSINESS OR INDUSTRY CAMPBELL - FRAZIER							
11. BIRTHPLACE (City and state or country) OHIO							
12. CITIZEN OF WHAT COUNTRY U. S. A.							
13a. FATHER'S NAME JAMES E. MC ELHINNY							
13b. MOTHER'S MAIDEN NAME ELLA COOK							
14. NAME OF HUSBAND OR WIFE BESS B. MC ELHINNY							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO							
16. SOCIAL SECURITY NO.							
17. INFORMANT Address MRS. BESS B. MC ELHINNY 4828 PARK							
18. CAUSE OF DEATH (Enter only one cause per line) <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%; border: none;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis about DUE TO (b) Atherosclerosis DUE TO (c) Cholelithiasis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. </td> <td style="width: 20%; border: none; vertical-align: top;"> INTERVAL BETWEEN ONSET AND DEATH 15 mins. 8 yrs 4 yrs </td> </tr> <tr> <td colspan="2" style="border: none;"> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) </td> </tr> <tr> <td colspan="2" style="border: none;"> 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 </td> </tr> </table>		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis about DUE TO (b) Atherosclerosis DUE TO (c) Cholelithiasis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	INTERVAL BETWEEN ONSET AND DEATH 15 mins. 8 yrs 4 yrs	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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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 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.)							
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 <u>July 26-1963</u> to <u>Aug 1-1963</u> and last saw ^{them} him alive on <u>July 31-1963</u> Death occurred at <u>1.05 AM. 8-1-1963</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) A. B. Boyer D.O.							
22b. ADDRESS 5529 Troost							
22c. DATE SIGNED 8/2/1963							
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL							
23b. DATE 8-3-1963							
23c. NAME OF CEMETERY OR CREMATORY ROSE HILLS MEMORIAL PARK							
23d. LOCATION (City, town, or county) (State) LONG BEACH, CALIFORNIA							
24. FUNERAL DIRECTOR ADDRESS C. H. BLACKMAN & SON, INC. K. C., MO.							
25. DATE RECD. BY LOCAL REG. 8-2-63							
26. REGISTRARS SIGNATURE <i>Ruth Long</i>							

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF **B. B. OYER** MEDICAL CERTIFICATION

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 Rest B. Bennett

Licensed Embalmer No. 4656

P.O. Address A.C., 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.