

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**63-032421**

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4364

DO NOT WRITE ON THIS STUB

AMENDED

**FILED AUG 20 1963**

VS 300	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	DOCUMENT
Rev. 4/59			
1			
2 <u>3908</u>			
3			
4 <u>0</u>			
5 <u>1</u>			
6			
7 <u>1</u>			
8 <u>1</u>			
9 <u>9451X</u>			
10			
11			
12 <u>50-0</u>			
13			
INSTEAD OF		MEDICAL CERTIFICATION	BY AFFIDAVIT OF
ITEM NO. SHOULD READ			
USE BLACK INK OR TYPEWRITER RIBBON			
Walter P. Jacob			

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>JACKSON</u>		a. STATE <u>MISSOURI</u> COUNTY <u>JACKSON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u>		c. CITY OR TOWN <u>KANSAS CITY</u>	
Length of stay in 1b <u>14 YRS.</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>BAPTIST MEMORIAL</u>		d. STREET ADDRESS (If outside, give location) <u>1167 EAST 77 TERRACE</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Eyes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED			4. DATE OF DEATH
First <u>LEWIS</u> Middle <u>WILFRED</u> Last <u>ROBICHAUD</u>			Month <u>AUG.</u> Day <u>2,</u> Year <u>1963</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4-20-1914</u>
9. AGE (last birthday) <u>49</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PACKAGING</u>	11. BIRTHPLACE (City and state or country) <u>WESTBROOK, MAINE</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13. FATHER'S NAME <u>ANTHONY ROBICHAUD</u>	
14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		15. NAME OF HUSBAND OR WIFE <u>MABEL ROBICHAUD</u>	
16. SOCIAL SECURITY NO. <u>322</u>		17. INFORMANT <u>MABEL ROBICHAUD</u>	
18. CAUSE OF DEATH (Enter only one cause per time for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Rupture of dissecting aneurysm</u>		<u>1 day</u>	
DUE TO (b) <u>Dissecting aortic aneurysm</u>		<u>14 hrs</u>	
DUE TO (c) <u>Arterio-sclerosis</u>		<u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in Part I (a) <u>Diabetes mellitus</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	
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 <u>8:55</u> a.m. Month, Day, Year <u>Aug 1st 1963</u>		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.) <u>Home</u>		20f. CITY, TOWN, OR LOCATION <u>Kansas City, Missouri</u>	
21. I attended the deceased from <u>Aug 1st 1963</u> to <u>Aug 2nd 1963</u> and last saw him alive on <u>Aug 2nd 1963</u>			
Death occurred at <u>8:55 a.m.</u> on the date stated above, and to the best of my knowledge from the causes stated.			
22a. SIGNATURE <u>Walter P. Jacob</u> (Deputy or title)		22b. ADDRESS <u>701 E 63 St</u>	
22c. DATE SIGNED <u>8/3/63</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b. DATE <u>August 6, 1963</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>	
23d. LOCATION (City, town, or county) <u>Kansas City, Missouri</u>		24. FUNERAL DIRECTOR <u>WORNALL FUNERAL HOME INC. K.C. Mo. 8-5-63</u>	
25. DATE RECD. BY LOCAL REG. <u>8-5-63</u>		26. REGISTRAR'S SIGNATURE <u>W. H. Long</u>	

DR. JACOBS  
701-5632

**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 W.C. Reine

Licensed Embalmer No. 4879

P. O. Address K.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.