

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-032472

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4467 STATE FILE NUMBER

FILED AUG 28 1963

DO NOT WRITE ON THIS STUB

AMENDED

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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

BY AFFIDAVIT OF

CHARLES A. KENDALL
MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Length of stay in 1b 3 days	c. CITY OR TOWN INDEPENDENCE
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION JACKSON CO. HOSP.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 912 SOUTH NOLAND
3. NAME OF DECEASED (Type or print) First ANNA Middle SUTTON Last		4. DATE OF DEATH Month AUGUST Day 9 Year 1963	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1/19/1888
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY ----	9. AGE (last birthday) 75
13a. FATHER'S NAME DAVID J. ARENDS		13b. MOTHER'S MAIDEN NAME AMELIA SCHREIBER	11. BIRTHPLACE (City and state or country) KANSAS CITY, MO.
14. NAME OF HUSBAND OR WIFE WALTER SUTTON - Dec'd.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
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. NO	17. INFORMANT JOHN ARENDS Address 11212 E. 45th KANSAS CITY
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis Cerebral arteriosclerosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, but not related to the terminal disease condition given in PART I (a) Diabetes mellitus			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 8-7-63 , to 8-9-63 and last saw her/him alive on 8-8-63 Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Charles A. Kendall MD		22b. ADDRESS 10901 Wanner Road Indeg.	22c. DATE SIGNED 8-9-63
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 8/12/1963	23c. NAME OF CEMETERY OR CREMATORY MT. WASHINGTON	23d. LOCATION (City, town, or county) (State) INDEPENDENCE, MO.
24. FUNERAL DIRECTOR ADDRESS GEO. .C CARSON & SONS INDEP., MO.		25. DATE RECD. BY LOCAL REG. 8-9-63	26. REGISTRAR'S SIGNATURE Ruth Long

USE BLACK INK OR TYPEWRITER RIBBON

ASCE

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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 *Kenneth Patterson*

Licensed Embalmer No. 4697

P. O. Address *Indy, 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.