

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-032474

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4321

DO NOT WRITE ON THIS STUB

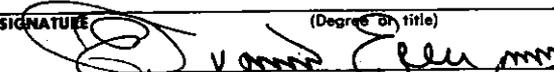
AMENDED

FILED AUG 20 1963

VS 300 Rev. 4/59	DATE AMENDED
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23318	
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4 2	
5 0	
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7 1	
8 1	
9490 X	
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12 57-0	
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

DOCUMENT

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> COUNTY <u>JACKSON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Length of stay in 1b <u>30 YRS</u>	c. CITY OR TOWN <u>KANSAS CITY</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>General Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1001-E-18</u> Reside on Farm. Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle _____ Last <u>Thomas</u>			4. DATE OF DEATH Month <u>July</u> Day <u>30</u> Year <u>1963</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12-25-1902</u>
9. AGE (last birthday) <u>60</u>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MISC.</u>	11. BIRTHPLACE (City and state or country) <u>LITTLE ROCK ARK. U.S.A.</u>
12. CITIZEN OF WHAT COUNTRY		13a. FATHER'S NAME <u>UNKNOWN</u>	
13b. MOTHER'S MAIDEN NAME <u>FRANCES R. CHARDSON</u>		14. NAME OF HUSBAND OR WIFE <u>MAR BROWN, 1311 GARFIELD</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>MAR BROWN, 1311 GARFIELD</u>		Address <u>R.C., Mo</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar pneumonia</u> DUE TO (b): _____ DUE TO (c): _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			
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 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 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 <u>7-30-63</u>	COUNTY _____ STATE _____
21. I attended the deceased from <u>7-30-63</u> to <u>7-30-63</u> and last saw her alive on <u>7-30-63</u> Death occurred at <u>7:30 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE 		22b. ADDRESS <u>2400 Cherry</u>	22c. DATE SIGNED <u>8-1-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>8-5-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>HIGHLAND</u>	23d. LOCATION (City, town or county) (State) <u>KANSAS CITY, MO.</u>
24. FUNERAL DIRECTOR <u>A.M. HUDSON, K.C., MO.</u>		25. DATE RECD. BY LOCAL REG. <u>8-2-63</u>	26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>

USE BLACK INK OR TYPEWRITER RIBBON

ITEM NO. SHOULD READ

MEDICAL CERTIFICATION

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.