

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-032528

STATE FILE NUMBER

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 398

DO NOT WRITE ON THIS STUD AMENDED

FILED AUG 29 1963

VS 300 Rev. 4/59	DATE AMENDED
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 BY AFFIDAVIT OF  
 ITEM NO. SHOULD READ

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> b. COUNTY <u>JACKSON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>INDEPENDENCE</u>		Length of stay in 1b <u>1 DAY</u>	c. CITY OR TOWN <u>RAYTOWN</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR HOME NURSING HOME INSTITUTION: <u>3713 HARDY</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) <u>9001 EAST 59<sup>1/2</sup> STREET</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>SARAH</u> Middle <u>ELIZABETH</u> Last <u>COLMAN</u>			4. DATE OF DEATH Month <u>AUGUST</u> Day <u>25</u> Year <u>1963</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3-8-1875</u>
9. AGE (last birthday) <u>88</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>HOME MAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>	11. BIRTHPLACE (City and state or country) <u>MYERSTOWN, PENNSYLVANIA</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>WINFIELD SCOTT LIVENGOOD</u>	
13b. MOTHER'S MAIDEN NAME <u>REBECCA NOLL</u>		14. NAME OF HUSBAND OR WIFE <u>THOMAS COLMAN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <u>MRS. C. LEE KENAGY</u>		Address <u>9821 EAST 64<sup>TH</sup> TERR.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>Arteria sclerosis - generalized</u> 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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>
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 checked="" 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 1949</u> to <u>8-24-63</u> and last saw her <u>alive</u> on <u>8-24-63</u> Death occurred at <u>7:00 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>D.W. Newcomer M.D.</u> (Degree or title)		22b. ADDRESS <u>9406 E. 63rd St.</u>	
22c. DATE SIGNED <u>8-26-63</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	
23b. DATE <u>AUG. 27, 1963</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FOREST HILL CEMETERY</u>	
23d. LOCATION (City, town, or county) <u>KANSAS CITY MISSOURI</u>		24. FUNERAL DIRECTOR <u>D.W. NEWCOMER'S SONS</u> ADDRESS <u>1331 BRUSH CREEK BLVD. KANSAS CITY, MO</u>	
25. DATE RECD. BY LOCAL REG. <u>8-26-63</u>		26. REGISTRAR'S SIGNATURE <u>Alta L. Craig</u>	

USE BLACK INK OR TYPEWRITER RIBBON

8-26-65

Dr. Willard M. Hubbard - 72-6-1060  
9406 East 63rd Street - Raytown, Mo.  
9:00-12:00 - 1:30-5:00 F.I.L.P.  
Raytown Clinic  
8-26-65

**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

*Dean W. Huff*

Licensed Embalmer No. 4414

P. O. Address Indep, 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.