

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-032533

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED AUG 30 1963 Primary Registration District No. 3026 Registrar's No. 399

VS 300  
Rev. 4/59

1 7005

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Independence</b>		Length of stay in 1b <b>1</b>	c. CITY OR TOWN <b>Independence</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Independence Sanitarium + Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1603 Appleton</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Stewart E EDIE</b>			4. DATE OF DEATH Month Day Year <b>Aug. 25, 1963</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>12/18/78</b>
9. AGE (last birthday) <b>84</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pharmacist-Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Drugs</b>	11. BIRTHPLACE (City and state or country) <b>Camden, Mo.</b>
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13a. FATHER'S NAME <b>Wm W. Edie</b>	
13b. MOTHER'S MAIDEN NAME <b>Maude Stewart</b>		14. NAME OF HUSBAND OR WIFE <b>MAUDE A. EDIE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <b>No</b>		16. SOCIAL SECURITY NO. <b>59</b>	17. INFORMANT <b>Maude A. Edie 1603 Appleton Independence Mo</b> Address
18. CAUSE OF DEATH (Enter only one cause per item for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart failure + Pneumonia</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>arteriosclerotic cardiovascular disease</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>years</b>
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"/> N- <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 <b>July 63</b> to <b>8/25/63</b> and last saw him alive on <b>8/25/63</b> Death occurred at <b>2:03 p</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Vance E. Lutz, M.D.</b> (Degree or title)		22b. ADDRESS <b>10901 Union St Independence, Mo</b>	22c. DATE SIGNED <b>8/25/63</b> (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>Aug 26 63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cremation - Kansas City, Kansas</b>	23d. LOCATION (City, town, or county)
24. FUNERAL DIRECTOR <b>R.H. Medical</b> ADDRESS <b>KB Kansas</b>	25. DATE RECD. BY LOCAL REG. <b>8-26-63</b>	26. REGISTRAR'S SIGNATURE <b>Alba L. Cray</b>	

USE BLACK INK OR TYPEWRITER RIBBON

AUG 30 1963

8-26-63

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 Frank W. Long

Licensed Embalmer No. 7015 KUMC  
P. O. Address 3940 Pavilion

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.

8-26-63