

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-035476

STATE FILE NUMBER

Registration District No. 72 Primary Registration District No. 3013 Registrar's No. 216

DO NOT WRITE ON THIS STUB

AMENDED

FILED SEP 20 1963

VS 300 Rev. 4/59	DATE AMENDED
1 <u>6004</u>	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF DOCUMENT
2 <u>6004</u>	
3	
4 <u>1</u>	
5 <u>2</u>	
6	
7 <u>0</u>	
8 <u>0</u>	
9 <u>4201</u>	
10	
11	
12 <u>6-0</u>	
13 <u>20</u>	
ITEM NO.	SHOULD READ

1. PLACE OF DEATH a. COUNTY <u>Clay</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Clay</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>North Kansas City</u>		c. CITY OR TOWN <u>Kansas City North</u>				
Length of stay in 1b <u>3 days</u>		Inside Limits <input checked="" type="checkbox"/> No <input type="checkbox"/>				
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>N.K.C. MEMORIAL HOSPITAL</u>		d. STREET ADDRESS (If outside, give location) <u>909 E. Barry Rd.</u>				
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>Shidler</u> Last <u>Shidler</u>			4. DATE OF DEATH Month <u>September</u> Day <u>18</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>8-5-1879</u>	9. AGE (last birthday) <u>84</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>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (City and state or country) <u>Harrisonville, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>William Millington</u>		13b. MOTHER'S MAIDEN NAME <u>Clara Cordell</u>		14. NAME OF HUSBAND OR WIFE <u>Larkin Shidler</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. <u>[REDACTED]</u>		17. INFORMANT Address <u>Mrs Goldie Miller 909 E. Barry Rd.</u>		
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2-3 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____						
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 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 COUNTY STATE
21. I attended the deceased from <u>4-2-63</u> to <u>9-18-63</u> and last saw her alive on <u>9-18-63</u> Death occurred at <u>8:50 PM</u> m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Deceased or title) <u>William L. Spertman</u>				22b. ADDRESS <u>8400 No Oak Ke 5576</u>		22c. DATE SIGNED <u>9-20-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>9-21-1963</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>St. Joseph, Mo.</u>
24. FUNERAL DIRECTOR <u>Harry Butler</u> ADDRESS <u>2100 E. Russell Rd.</u>			25. DATE RECD. BY LOCAL REG. <u>9-21-63</u>		26. REGISTRAR'S SIGNATURE <u>Marguerite Hudgens</u>	

USE BLACK INK OR TYPEWRITER RIBBON

MEDICAL CERTIFICATION BY AFFIDAVIT OF

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 Harry Butler
Licensed Embalmer No. 2845

P. O. Address 2100 E Russell Rd KCMO

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.