

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-036309

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4908

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

BY AFFIDAVIT OF George O. Miles MEDICAL CERTIFICATION

FILED SEP 23 1963		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>Johnson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Length of stay in 1b <u>30 days</u>		c. CITY OR TOWN <u>Knob Noster</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Luke's Hospital</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Box 201</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Louise Martin</u>			4. DATE OF DEATH Month Day Year <u>9-6-63</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11-19-15</u>	9. AGE (last birthday) <u>47 yrs.</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days 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>Eldorado, Arkansas</u>	
12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>		13a. FATHER'S NAME <u>Norton Tompkins, Sr.</u>		13b. MOTHER'S MAIDEN NAME <u>Edna Word</u>	
14. NAME OF HUSBAND OR WIFE <u>Ralph A. Martin</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>none</u>	
17. INFORMANT <u>Ralph A. Martin, Knob Noster, Mo.</u>		18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL ANOXIA</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 mo</u>	
DUE TO (b) <u>metastatic intracranial mammary carcinoma</u>		DUE TO (c) _____		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Metastatic mammary carcinoma to liver, skeleton, & brain</u>	
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		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 COUNTY STATE		21. I attended the deceased from <u>Dec. 1, 1962</u> to <u>Sept 6, 1963</u> and last saw her alive on <u>Sept. 5, 1963</u> Death occurred at <u>7:15/AM</u> m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>George O. Miles, M.D.</u>		22b. ADDRESS <u>4320 Wornall Road Kansas City, Missouri</u>		22c. DATE SIGNED <u>9/6/63</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Removal</u>		23b. DATE <u>9-8-63</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Cemetery</u>	
23d. LOCATION (City, town, or county) <u>Homer, Louisiana</u>		24. FUNERAL DIRECTOR <u>Melody-McGilley-Eylar Funeral Home</u>		25. DATE RECD. BY LOCAL REG. <u>9-6-63</u>	
26. REGISTRAR'S SIGNATURE <u>Bessie Smith</u>		20. ADDRESS <u>Linwood & WOODLAND</u>		25. DATE RECD. BY LOCAL REG. <u>9-6-63</u>	

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

James E. Becklerman

Licensed Embalmer No. 4573

P. O. Address K.C. 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.

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