

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-037284
STATE FILE NUMBER

Registration District No. 314 Primary Registration District No. 6066 Registrar's No. 57

DO NOT WRITE ON THIS STUB

FILED OCT 7 1963

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>St. Clair</u>		a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Roscoe ^{to} Rural</u> Length of stay in 1b <u>Six Hrs;</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>Sac-Osage Heights</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>3709 East 8th;</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Gordon D. Stillie</u>			4. DATE OF DEATH <u>Sept; 14, 1963</u> Month Day Year
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4/17/03</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>Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Midland Mfg; Co;</u>	11. BIRTHPLACE (City and state or country) <u>Junction City Kansas USA</u>
12. CITIZEN OF WHAT COUNTRY		13a. FATHER'S NAME <u>Gordon D. Stillie</u>	
13b. MOTHER'S MAIDEN NAME <u>Fannie Kay</u>		14. NAME OF HUSBAND OR WIFE <u>Ethel D. Stillie</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT Address
18. CAUSE OF DEATH (Enter only one cause per line)			INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) <u>Probable myocardial infarct</u>			
DUE TO (b) <u>Arterio sclerotic heart disease</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)			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 checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>while mowing lawn</u>	
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.) <u>Home</u>		20f. CITY, TOWN, OR LOCATION <u>Osceola Missouri</u> COUNTY STATE	
21. I attended the deceased from <u>only at death</u> and last saw her him alive on _____ Death occurred at <u>4:00 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Thomas Williams M.D.</u>		22b. ADDRESS <u>Osceola Missouri</u>	22c. DATE SIGNED <u>Sept. 14, 63</u> (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>9-17-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Forest Hill</u>	23d. LOCATION (City, town, or county) <u>Kansas City Missouri</u> (State)
24. FUNERAL DIRECTOR <u>Goodrich Funeral Home, Osceola Mo.</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>10-5-63</u>	26. REGISTRAR'S SIGNATURE <u>Ruth Seavers</u>

USE BLACK INK OR TYPEWRITER RIBBON

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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 J. B. Goodrich

Licensed Embalmer No. 3038

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.