

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-040070

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5642

FILED NOV 4 1963

DO NOT WRITE ON THIS STUB

AMENDED

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u> b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u> Length of stay in 1b <u>1 MONTH</u> c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BAPTIST MEMORIAL HOSPITAL</u> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>KANSAS</u> b. COUNTY <u>JOHNSON</u> c. CITY OR TOWN <u>SHAWNEE</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (if outside, give location) <u>3001 WEST 48TH TERR</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>PAULINE</u> Middle <u>W.</u> Last <u>NOONAN</u>			4. DATE OF DEATH Month <u>OCTOBER</u> Day <u>17</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>1/18/1895</u>	9. AGE (last birthday) <u>68</u>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OFFICE WORKER</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>DR. CHARLES WHITE</u>	11. BIRTHPLACE (City and state or country) <u>LEBANON, MISSOURI</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>CHARLES H. WHITE</u>		13b. MOTHER'S MAIDEN NAME <u>LAURA GRAVES</u>		14. NAME OF HUSBAND OR WIFE <u>JOHN L. NOONAN</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. BETTY ANN PEER</u> Address <u>420 NORTH SIXTH HANNIBAL, MO.</u>				
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>diffuse carcinomatous carcinoma of ovary</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) _____								INTERVAL BETWEEN ONSET AND DEATH <u>3 mo.</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. SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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>July 63</u> to <u>Oct 17 63</u> and last saw her/him alive on <u>Oct 16 63</u> Death occurred at <u>5:12 A.</u> m on the date, stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>Charles H. White M.D.</u>				22b. ADDRESS <u>6518 Overhill Rd.</u>		22c. DATE SIGNED <u>10/17/63</u>		
23a. BURIAL, CREMATION, REMOVAL. (Specify) <u>BURIAL</u>	23b. DATE <u>OCT. 19, 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT. WASHINGTON CEM.</u>	23d. LOCATION (City, town, or county) <u>KANSAS CITY MISSOURI</u>					
24. FUNERAL DIRECTOR <u>D.W. NEWCOMB & SONS</u> ADDRESS <u>1331 BAUSH CREEK KANSAS CITY MO</u>		25. DATE RECD. BY LOCAL REG. <u>10-18-63</u>	26. REGISTRAR'S SIGNATURE <u>Bessie Smith</u>					

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

Charles H. White MEDICAL CERTIFICATION

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 John V. Hemel

Licensed Embalmer No. 4848

P. O. Address K. C. 17, 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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