

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-043893

6003 STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6003

**FILED NOV 21 1963**

DO NOT WRITE ON THIS STUD

AMENDED

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

W. Small

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>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kansas City</u>		Length of stay in 1b <u>about 1-yr.</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) <u>Children's Mercy Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>3722 E. 9th</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Kelly</u> Middle <u>Suzanne</u> Last <u>Eisenhower</u>			4. DATE OF DEATH Month <u>11</u> Day <u>3</u> Year <u>1963</u>
5. SEX <u>7</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2-13-1962</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CR:ld</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CR:ld</u>	9. AGE (last birthday) <u>1</u> IF UNDER 1 YEAR: Months <u>9</u> Days <u></u> Hours <u></u> Min. <u></u> IF UNDER 24 HR: Hours <u></u> Min. <u></u>
11. BIRTHPLACE (City and state or country) <u>Marshalltown, Iowa</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>William A. Eisenhower Jr.</u>		13b. MOTHER'S MAIDEN NAME <u>Delores Vickery</u>	
14. NAME OF HUSBAND OR WIFE <u>Same</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>[redacted]</u>		17. INFORMANT <u>father</u> Address: <u>Same</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral edema</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 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 <u></u> a.m. <u></u> p.m. <u></u> Month, Day, Year <u></u>	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>6:55pm 11/3/1963</u> to <u>8:30pm 11/3/1963</u> and last saw her alive on <u>11/3/1963</u> Death occurred at <u>8:30 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>W. Small M.D.</u>		22b. ADDRESS <u>1710 Independence Ave L.P.M.</u>	22c. DATE SIGNED <u>11-4-63</u>
23a. MORTAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>Nov-5-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Maple Hill</u>
24. FUNERAL DIRECTOR <u>Gates - 1901 Olathe Blvd, Kansas City, Ki</u>		25. DATE RECD. BY LOCAL REG. <u>11-5-63</u>	26. REGISTRAR'S SIGNATURE <u>Bessie Smith</u>

MI-216-2118

**STATEMENT BY LICENSED EMBALMER**

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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 Paul S. Williamson

Licensed Embalmer No. 5009

P. O. Address Overland Park, 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.