

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

6213-043908
STATE FILE NUMBER

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

DO NOT WRITE ON THIS STUB
AMENDED

FILED DEC - 2 1963

VS 300 Rev. 4/59	DATE AMENDED	
1		
23378		
3		
4 1		
5 2		
6		
7 0		
8 0		
9420.1		
10		
11		
12 86-0		
13		

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</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>22 yrs</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 of HOSPITAL OR INSTITUTION <u>College Ave New Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>2425 College</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>CARRIE</u> Middle <u>FIELD</u> Last <u>FIELD</u>		4. DATE OF DEATH Month <u>11</u> Day <u>12</u> Year <u>1963</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>Wh</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>5-26-1890</u>
9. AGE (last birthday) <u>73</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>Home</u>		10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (City and state or country) <u>St Joseph, Mo</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Cal Hill</u>	
13b. MOTHER'S MAIDEN NAME <u>Addie</u>		14. NAME OF HUSBAND OR WIFE -	
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. [REDACTED]	
17. INFORMANT <u>Jackson County Welfare Kc, Mo</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> DUE TO (b) <u>HYPERTENSION</u> DUE TO (c) <u>ARTERIOSCLEROSIS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>8 years</u> <u>12 years</u>
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>5-10-63</u> to <u>11-12-63</u> and last saw her/him alive on <u>11-12-63</u> Death occurred at <u>4:15 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22. SIGNATURE (Degree or title) <u>Frank Paul Lawrence M.D.</u>		22b. ADDRESS <u>428 So. White Ave</u>	22c. DATE SIGNED <u>11-12-63</u>
23a. DATE OF CREMATION, REMOVAL (Specify)	23b. DATE <u>11-16-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt Calvary</u>	23d. LOCATION (City, town, or county) <u>Kansas City Kans.</u>
24. FUNERAL DIRECTOR <u>Leventine Bros Kc, Mo.</u>		25. DATE REC'D. BY LOCAL REG. <u>11-15-63</u>	26. REGISTRAR'S SIGNATURE <u>Beaie Smith</u>

USE BLACK INK OR TYPEWRITER RIBBON

415 Am. Dr. Lammiana
11-12-63

OFFICE OF THE BOARD OF EXAMINERS

87-8
1
2
3
4

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 Al Passantino

Licensed Embalmer No. 4554

P. O. Address KC 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.