

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

6654 **63-048065**
STATE FILE NUMBER

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

FILED DEC 19 1963

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 lb <u>504m</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>General Hospital Med. Ct.</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>mo.</u> b. COUNTY <u>Jackson</u> c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS <u>1701 E. 8th</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
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3. NAME OF DECEASED (Type or print) First <u>Dora</u> Middle <u>May</u> Last <u>Hughes</u>			4. DATE OF DEATH Month <u>December</u> Day <u>6</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>7-3-1887</u>	9. AGE (last birthday) <u>76</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____ 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>Manager</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Hotel</u>	11. BIRTHPLACE (City and state or country) <u>Delphos, Kansas</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>Charles E Edwards</u>	13b. MOTHER'S MAIDEN NAME <u>Ella Shroyer</u>	14. NAME OF HUSBAND OR WIFE <u>Fred Hughes</u>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT <u>Frank Edwards</u> <u>Winifred H.</u> Address _____
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>massive infarction</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)
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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
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21. I attended the deceased from 12-6-63 to 12-6-63 and last saw her/him alive on 12-6-63
 Death occurred at 1:25 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>[Signature]</u> (Degree or title)	22b. ADDRESS <u>2400 Cherry</u>	22c. DATE SIGNED <u>12-9-63</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12/10/63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>	23d. LOCATION (City, town, or county) (State) <u>Kansas City Mo</u>
24. FUNERAL DIRECTOR ADDRESS <u>C. H. Blackman 4501 N. C. Mo</u>		25. DATE RECD. BY LOCAL REG. <u>12-9-63</u>	26. REGISTRAR'S SIGNATURE <u>Bessie Smith</u>

(Licensed Embalmer's Statement on Reverse Side)

DO NOT WRITE ON THIS STUB
 AMENDED
 DATE AMENDED
 1
 2 3158
 3
 4 1
 5 2
 6
 7 1
 8
 9 7953
 10
 11
 12 57-0
 13
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 BY AFFIDAVIT OF
 STATE CLERK
 MEDICAL CERTIFICATION
 SHOULD READ
 ITEM NO.

USE BLACK INK OR TYPEWRITER RIBBON

EMBALMENT

STATE

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 Bert B. Bennett

Licensed Embalmer No. 4654

P. O. Address R.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.