

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-048128

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6509 STATE FILE NUMBER

FILED DEC 19 1963

1. PLACE OF DEATH e. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	
Length of stay in 1b 72 Yrs.		Inside Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DOA Lakeside Hospital		d. STREET ADDRESS (If outside, give location) 3537 Wyandotte	
Inside Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First HULDA Middle H. Last MC CULLOUGH			4. DATE OF DEATH Month December Day 1 Year 1963		
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5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8-29-1891	9. AGE (last birthday) 72	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Kansas City, Mo.		12. CITIZEN OF WHAT COUNTRY U. S. A.	
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13a. FATHER'S NAME Peter Hanson		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE George T. Mc Cullough	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address George T. Mc Cullough Kansas City, Mo	
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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:			INTERVAL BETWEEN ONSET AND DEATH sudden
IMMEDIATE CAUSE (a) Cerebro-vascular accident			
DUE TO (b) arterio-sclerosis			
DUE TO (c) acute chngs.			

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	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)	
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20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. Month, Day, Year					
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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.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
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21. I attended the deceased from 11/30/63 to 12/2/63 and last saw her him alive on 12/1/63
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>Gerard Zauder MD</i>		22b. ADDRESS 1001 E 49th St		22c. DATE SIGNED 12/2/63	
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-3-63		23c. NAME OF CEMETERY OR CREMATORY Elmwood Cemetery		23d. LOCATION (City, town, or county) (State) Kansas City, Mo.	
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24. FUNERAL DIRECTOR ADDRESS Freeman Mortuary Kansas City, Mo.		25. DATE RECD. BY LOCAL REG. 12-2-63		26. REGISTRAR'S SIGNATURE <i>Bessie Smith</i>	
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(Licensed Embalmer's Statement on Reverse Side)

DO NOT WRITE ON THIS STUB

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

DOCUMENT

MEDICAL CERTIFICATION
Gerard Zauder

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

DR. ZAUIER

1001 E. 47TH

17-3

STATEMENT BY LICENSED EMBALMER

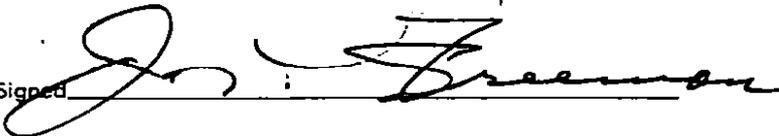
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed 

Licensed Embalmer No. 2939

P. O. Address K. O. 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.