

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

651863-048286

DO NOT WRITE ON THIS STUB  
 AMENDED

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>15 YEARS</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. LUKES HOSPITAL</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u> c. CITY OR TOWN <u>KANSAS CITY</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>1324 EAST 108TH ST.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED First Middle Last <u>MABEL E. THOMPSON</u>	
4. DATE OF DEATH <u>DECEMBER 1 - 1963</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>CAUC.</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>7-16-1883</u>
9. AGE (last birthday) <u>80 YEARS</u>	IF UNDER 1 YEAR 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>—</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>
11. BIRTHPLACE (City and state or country) <u>CLINTON, MO.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>GEORGE FREEMAN</u>	13b. MOTHER'S MAIDEN NAME <u>CHARLOTTE CUPID</u>
14. NAME OF HUSBAND OR WIFE <u>JAMES W. THOMPSON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	17. INFORMANT <u>JOHN TOOTLE 3110 JACKSON</u>
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>CONGESTIVE HEART FAILURE</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 mos.</u> DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> <u>15 YEARS.</u> 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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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.) _____	
20c. TIME OF INJURY Hour a.m. Month Day, Year _____	
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 _____	
21. I attended the deceased from <u>OCTOBER 1948</u> to <u>DECEMBER 1963</u> and last saw her alive on <u>DECEMBER 1963</u> Death occurred at <u>7:00 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>George K. Landis, M.D.</u>	22b. ADDRESS <u>1630 Professional Bldg</u>
22c. DATE SIGNED <u>12/2/63</u>	
23a. BURIAL, CREMATION, REMOVAL, (Specify) <u>BURIAL</u>	23b. DATE <u>DEC 4, 1963</u>
23c. NAME OF CEMETERY OR CREMATORY <u>CROWN Hill</u>	23d. LOCATION (City, town, or County) (State) <u>Eycelsior Springs Mo.</u>
24. FUNERAL DIRECTOR <u>MUEHLEBACH</u> ADDRESS <u>6800 TROOST</u>	25. DATE RECD. BY LOCAL REG. <u>12-2-63</u>
26. REGISTRAR'S SIGNATURE <u>Bessie Smith</u>	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 SHOULD READ  
 ITEM NO.

VS 300	Rev. 4/59	1	2	3	4	5	6	7	8	9	10	11	12	13
		38	1	2	0	2	200	66-0						

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT  
 BY AFFIDAVIT OF George K. Landis MEDICAL CERTIFICATION

Dr. K. Landes  
Prof Bldg

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

*Robert Landes*

Licensed Embalmer No.

5103

P. O. Address

K. 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.