

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 001 64 Primary Registration District No. 3026 Registrar's No. 40031777 STATE FILE NUMBER

VS 300 Rev. 4/59	DATE AMENDED	
1 <u>7005</u>		
2 <u>7005</u>		
3 <u>2</u>		
4 <u>0</u>		
5 <u>1</u>		
6		
7 <u>1</u>		
8 <u>2</u>		
9 <u>4/201</u>		
10		
11		
12 <u>90-0</u>		
13 <u>1-0</u>		

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF
SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

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> COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Independence</u>		Length of stay in 1b <u>60 yrs.</u>	c. CITY OR TOWN <u>Independence</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1509 Maywood</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1509 Maywood</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>MR. ALLEN PERKINS SAUNDERS</u>			4. DATE OF DEATH Month Day Year <u>August 22, 1964</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 5, 1879</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cabinet maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>W. Virginia</u>	9. AGE (last birthday) <u>85</u> IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
11. BIRTHPLACE (City and state or country) <u>Red Sulphur Springs</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>James K. Saunders</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Ann Weatherford</u>	14. NAME OF HUSBAND OR WIFE <u>Ethel Saunders</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>490-09-0285</u>	17. INFORMANT Address <u>Mrs. Ethel Saunders 1509 Maywood, Indep., Mo.</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>Acute Myocardial Infarction</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u> <u>Days</u> <u>Unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Pulmonary Fibrosis, bronchiectasis</u>			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 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. p.m.	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>March '64</u> to <u>8-22-64</u> and last saw her/him alive on <u>8-17-64</u> Death occurred at <u>4 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>[Signature]</u> <u>MD</u>		22b. ADDRESS <u>10901 Winner Road Independence, Missouri</u>	22c. DATE SIGNED <u>8/24/64</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>August 25, 1964</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Blue Springs Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Blue Springs, Missouri</u>
24. FUNERAL DIRECTOR ADDRESS <u>OTT & MITCHELL, Indep., Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>8-25-64</u>	26. REGISTRAR'S SIGNATURE <u>Alba L. Craig</u>

(Licensed Embalmer's Statement on Reverse Side)

SEP 2 1964

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 *[Handwritten Signature]*

Licensed Embalmer No. 3156

P. O. Address *[Handwritten Address]*

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.

8-25-64