SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-012697
STATE FILE NUMBER

AMENDED

FILED MAY 15 1961

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 472

DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY: Buchanan
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St.Joseph — Length of stay in 1b: life
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Missouri Methodist Hosp. — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Buchanan
c. CITY OR TOWN: St. Joseph — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 1020 N. 18th St. — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: MARCIA Middle: MAE Last: KEPHART
4. DATE OF DEATH: Month: May Day: 3 Year: 1961
5. SEX: female
6. COLOR OR RACE: white
7. Married ☐ Never Married ☑ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 5/3/1961
9. AGE (last birthday): —— IF UNDER 1 YEAR: Months —— Days —— IF UNDER 24 HR: Hours — Min. 10
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): infant
10b. KIND OF BUSINESS OR INDUSTRY: ——
11. BIRTHPLACE (City and state or country): St. Joseph, Mo.
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: Charles Allen Kephart
13b. MOTHER'S MAIDEN NAME: Ava M. Anderson
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): ——
16. SOCIAL SECURITY NO.: ——
17. INFORMANT: Charles Kephart, Address: 1020 N.18th,St.Joseph,Mo.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prematurity — INTERVAL BETWEEN ONSET AND DEATH: 1 HOUR
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 BIRTH, to DEATH and last saw her/him alive on 3 May 61
Death occurred at 10:50 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): F. Gregg Thompson III
22b. ADDRESS: 902 Edmond
22c. DATE SIGNED: 6 May 61

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE: 5/4/1961
23c. NAME OF CEMETERY OR CREMATORY: Memorial Park Cemetery
23d. LOCATION (City, town, or county) (State): St. Joseph Missouri

24. FUNERAL DIRECTOR: Weston Bowman ADDRESS: St.Joseph,Mo.
25. DATE RECD. BY LOCAL REG.: May 9 1961
26. REGISTRAR'S SIGNATURE: Wm. Clark Hardell

(Licensed Embalmer's Statement on Reverse Side)

F. Gregg Thompson III, M.D. CERTIFICATION

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 William [illegible]

Licensed Embalmer No. 4535

P. O. Address St Joseph, 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.