

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-017661

AMENDED

3212 Registration District No. 149

Primary Registration District No. 1002 Registrar's No. 2102

STATE FILE NUMBER

FILED MAY 17 1961

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

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>MISSOURI</u> b. COUNTY <u>JACKSON</u>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u>		c. CITY OR TOWN <u>KANSAS CITY</u>	
Length of stay in lb _____		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>ST. LUKE'S</u>		d. STREET ADDRESS (If outside, give location) <u>3528 WYANDOTTE</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>"A" BABY GIRL MOLESWORTH</u>			4. DATE OF DEATH Month <u>3</u> Day <u>29</u> Year <u>61</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3-29-61</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) IF UNDER 1 YEAR IF UNDER 24 HR Months _____ Days _____ Hours _____ Min. _____
11. BIRTHPLACE (City and state or country) <u>KANSAS CITY MO</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>DALE RICHARD MOLESWORTH</u>		13b. MOTHER'S MAIDEN NAME <u>CAROL ANN LEWIS</u>	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 <u>DALE R. MOLESWORTH</u> Address <u>3528 WYANDOTTE K.C. 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>Thromboses in cerebral malformation of the heart.</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			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)			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 _____ Month, Day, Year _____ 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>3-29-61</u> to <u>3-29-61</u> and last saw him alive on <u>3-29-61</u> Death occurred at <u>11:07</u> P.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Name or title) <u>Leonard A. Wall M.D.</u>		22b. ADDRESS <u>4635 Wyandotte Kansas mo grad 27, 61</u>	22c. DATE SIGNED <u>MO</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>4/24/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Luke's Hosp.</u>	23d. LOCATION (City, town, or county) (State) <u>K.C. MO</u>
24. FUNERAL DIRECTOR <u>St. Luke's Hosp. K.C. - MO.</u>		25. DATE RECD. BY LOCAL REG. <u>4-28-61</u>	26. REGISTRAR'S SIGNATURE <u>St. Luke's Hosp</u>

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. _____

P. O. 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.