SSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

ITMENT OF PUBLIC HEALTH AND WELFARE

61-020592
STATE FILE NUMBER

AMENDED

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 136

FILED JUN 19 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY: Callaway
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Fulton
Length of stay in 1b: 23 yrs.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: State Hospital No. 1
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Jackson
c. CITY OR TOWN: Kansas City
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): —
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First COATS Middle Last MILTON
4. DATE OF DEATH: Month June Day 13 Year 1961
5. SEX: Male
6. COLOR OR RACE: Negro
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 5-26-1900
9. AGE (last birthday): 61
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (City and state or country): Kansas City, Mo.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Jim Milton
13b. MOTHER'S MAIDEN NAME: Lucy ?
14. NAME OF HUSBAND OR WIFE: —
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unk. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: —
17. INFORMANT: State Hospital No. 1, Fulton, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Aspiration pneumonia
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Uremia
DUE TO (c) Nephrosclerosis and chronic pancreatitis.
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. ☐ 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 State Hospital No. 1 Oct. 22, 1938 to June 13, 1961 and last saw ~~he~~ him alive on June 13, 1961
Death occurred at 5 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE: William V Lawrence MD (Degree or title)
22b. ADDRESS: State Hospital No. 1, Fulton, Mo.
22c. DATE SIGNED: 6/13/61
23a. BURIAL, CREMATION, REMOVAL (Specify)
23b. DATE: 6-14-61
23c. NAME OF CEMETERY OR CREMATORY: Anatomical Board
23d. LOCATION (City, town, or county): Columbia (State): Mo.
24. FUNERAL DIRECTOR: Robert A Johnston ADDRESS: Columbia Mo
25. DATE RECD. BY LOCAL REG.: June 14-1961
26. REGISTRAR'S SIGNATURE: Marietta Lawrence

(Licensed Embalmer's Statement on Reverse Side)

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_____ Signed_____
Signature of Student Embalmer

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.