

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-024037
STATE FILE NUMBER

38 Primary Registration District No. 3006 Registrar's No. 468
FILED AUG 7 1961

DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF
ITEM NO. SHOULD READ

1. PLACE OF DEATH a. COUNTY Boone		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Cole	
b. CITY (If outside corporate limits, give TOWNSHIP only) Columbia		Length of stay in 1b 6 days	c. CITY OR TOWN Jefferson City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Univ. of Mo. Medical Center		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 139 Boonville Rd. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Charles Middle Wesley Last Kenyon			4. DATE OF DEATH Month 7 Day 29 Year 61
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11-15-98
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Field supervisor, Employment Security		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) 62 IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HR: Hours <input type="checkbox"/> Min. <input type="checkbox"/>
11. BIRTHPLACE (City and state or country) Bethany, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME John Wesley Kenyon		13b. MOTHER'S MAIDEN NAME Hetta Burns	14. NAME OF HUSBAND OR WIFE Lola Mae Kenyon
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 Address Univ. of Mo. Medical Center Records - Columbia	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 1 year years.
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 type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. Month, Day, Year		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 7/22/61 to 7/29/61 and last saw ^{her} _{him} live on 7/29/61 Death occurred at 12:05 A. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) C. Thorge Ray M.D.		22b. ADDRESS Medical Center, Columbia, Mo.	22c. DATE SIGNED 7/29/61
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 7-29-61	23c. NAME OF CEMETERY OR CREMATORY Bethany	23d. LOCATION (City, town, or county) (State) Mo.
24. FUNERAL DIRECTOR ADDRESS Parker Funeral Service Columbia		25. DATE RECD. BY LOCAL REG. July 29 1961	26. REGISTRAR'S SIGNATURE Mrs R E Palmer

AUG 17 1961

AUG 7 1961

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

JW Phillips

Licensed Embalmer No. *4897*

P. O. Address *Columbus*

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.