

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**=61-036294**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 72 Primary Registration District No. 3013 Registrar's No. 187

**FILED OCT 31 1961**

1. PLACE OF DEATH a. COUNTY <u>Clay</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clay</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>North Kansas City</u>		c. CITY OR TOWN <u>North Kansas City</u>	
Length of stay in 1b		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>906 Swift</u>		d. STREET ADDRESS (If outside, give location) <u>906 Swift</u>	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Ingram</u> Last <u>Marshall</u>			4. DATE OF DEATH Month <u>October</u> Day <u>21</u> Year <u>1961</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc.</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>11-24-1900</u>	9. AGE (last birthday) <u>60</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Officer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>President Hotel</u>		11. BIRTHPLACE (City and state or country) <u>Springfield, Missouri</u>	
12. CITIZEN OF WHAT COUNTRY <u>U. S. AA</u>					

13a. FATHER'S NAME <u>Joseph E. Marshall</u>	13b. MOTHER'S MAIDEN NAME <u>Lula Ingram</u>	14. NAME OF HUSBAND OR WIFE <u>Mrs. Dorothy Marshall</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. _____	17. INFORMANT <u>Mrs. Dorothy Marshall-906 Swift N.K.C, Mo.</u>
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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>Unknown Probable Coronary Occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Acute</u>
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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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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. 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 \_\_\_\_\_, to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_.  
Death occurred at \_\_\_\_\_ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>State M.D. Coroner</u>	22b. ADDRESS <u>North Kansas City Mo.</u>	22c. DATE SIGNED <u>10/23/61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>10-24-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Merriam Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Bethany, Missouri</u>
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24. FUNERAL DIRECTOR <u>D.W. Newcomer's Sons-North Kansas City, Mo.</u>	ADDRESS <u>10-23-61</u>	25. DATE RECD. BY LOCAL REG. <u>10-23-61</u>	26. REGISTRAR'S SIGNATURE <u>Marquitta Higgins</u>
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(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1961 T ADN

**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 John H. Halsbeck  
Licensed Embalmer No. 4949  
P. O. Address No. Kansas City 16, 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.