

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

62-000316

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

042

Primary Registration District No. 1000

152

STATE FILE NUMBER

AMENDED

Registration District No.

FILED FEB 13 1962

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY Buchanan	b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph	a. STATE Missouri	b. COUNTY Jackson
Length of stay in 1b 1 yr		c. CITY OR TOWN Kansas City	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hospital #2	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location)	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First FRED	Middle	Last CARMAN	4. DATE OF DEATH	Month February	Day 8	Year 1962
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5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Dec. 1, 1901	9. AGE (last birthday) 60	IF UNDER 1 YEAR	IF UNDER 24 HR
				Months	Days	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) Missouri	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME Joe Carman	13b. MOTHER'S MAIDEN NAME Lucinda Shaw	14. NAME OF HUSBAND OR WIFE none
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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) no	16. SOCIAL SECURITY NO. --	17. INFORMANT Carl Carman	Address
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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:	INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Bronchopneumonia	3 day
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Mal-Nutrition, Dehydration	unknown
DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) C.B.S. associated with chronic alcoholism	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 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.)
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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
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21. I attended the deceased from Feb. 7, 1962 to Feb. 8, 1962 and last saw her alive on Feb. 7, 1962
 Death occurred at 5:55 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) H F Mundy M.D.	22b. ADDRESS St Joseph Mo	22c. DATE SIGNED Feb. 8-1962
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Feb. 8, 1962	23c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery	23d. LOCATION (City, town, or county) Kansas City, Kansas
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24. FUNERAL DIRECTOR (Name and Address) N W Newman Kansas City Kansas	25. DATE RECD. BY LOCAL REG. Feb. 8, 1962	26. REGISTRAR'S SIGNATURE Mrs Clark Hardell
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DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 BY AFFIDAVIT OF
 MEDICAL CERTIFICATION
 H.F. Mundy, M.D.
 SHOULD READ
 ITEM NO.

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. 4849

P. O. Address J. P. K.

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.