

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

48-62-001551 STATE FILE NUMBER

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

FILED JAN 18 1962

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> COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Length of stay in lb <u>New Born</u>	c. CITY OR TOWN <u>Raytown</u> 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. Mary's Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>6313 Hedges</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Roberta</u> Middle <u>Ann</u> Last <u>Carter</u>			4. DATE OF DEATH Month <u>January</u> Day <u>4</u> Year <u>62</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</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>1-4-62</u>	9. AGE (last birthday) IF UNDER 1 YEAR Months _____ Days _____ Hours _____	IF UNDER 24 HR Min <u>28</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>	

13a. FATHER'S NAME <u>James John Carter</u>		13b. MOTHER'S MAIDEN NAME <u>Vivian Agnes Wolf</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>Mrs James J. Carter</u> Address _____	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Anoxia

DUE TO (b) unknown

DUE TO (c) _____

CONDITIONS, if any, which gave rise to above cause (a), stating the underlying cause last.

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 N- Unknown

INTERVAL BETWEEN ONSET AND DEATH
Birth weight 9 lbs Length 23

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.)	
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 1/4/62 3:40 a.m. to 1/4/62 4:08 a.m. and last saw her live on 4:08 a.m. 1/4/62
Death occurred at 4:08 a.m. 1/4/62 m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>S. B. Montello M.D.</u> (Degree or title)		22b. ADDRESS <u>46209 C. Nichols Parkway</u>		22c. DATE SIGNED <u>1/4/62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>1/6/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet Cemetery</u>	
23d. FUNERAL DIRECTOR <u>Sheil Colonial Chapel K C Mo</u>		23e. ADDRESS		23d. LOCATION (City, town, or county) <u>Kansas City Missouri</u> (State)	

24. FUNERAL DIRECTOR <u>Sheil Colonial Chapel K C Mo</u>		25. DATE RECD. BY LOCAL REG. <u>1-6-62</u>		26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>	
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

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 *James A. Smith*

Licensed Embalmer No. 4954

P. O. Address J. C. Smith

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.