

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-002209

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 446 Primary Registration District No. 4237 Registrar's No. 63

FILED FEB 13 1962

AMENDED
DATE AMENDED
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF
ITEM NO. SHOULD READ

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>JACKSON</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>JACKSON</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>RAYTOWN</u> | | Length of stay in 1b <u>16 yrs.</u> | c. CITY OR TOWN <u>RAYTOWN</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF DECEASED (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>10304 E 70th TER</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>10304 E 70th TER</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>Berkley</u> Last <u>Whites</u> | | 4. DATE OF DEATH Month <u>Feb.</u> Day <u>4</u> Year <u>1962</u> | |
| 5. SEX <u>MALE</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>9-15-1896</u> |
| 9. AGE (last birthday) <u>65</u> | | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HR Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during last of working life, or if retired) <u>Water Dept.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>K.C. Mo.</u> | 11. BIRTHPLACE (City and state or country) <u>CLARENCE, Mo.</u> |
| 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | | 13a. FATHER'S NAME <u>JAMES B. Whites</u> | |
| 13b. MOTHER'S MAIDEN NAME <u>ELLEN SUMTER</u> | | 14. NAME OF HUSBAND OR WIFE <u>NONE</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> | | 16. SOCIAL SECURITY NO. <u>W/W F</u> | |
| 17. INFORMANT <u>6 Mrs. Elsie Mahon</u> | | Address <u>10304 E 70th Ter.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Coronary atherosclerosis</u> | | | <u>10 years</u> |
| 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 | |
| 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 <u>1-28-52</u> to <u>2-4-62</u> and last saw him alive on <u>12-6-61</u> Death occurred at <u>9:30</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE <u>D. Neubank M.D.</u> (Degree or title) | | 22b. ADDRESS <u>9406 E. 63rd</u> | 22c. DATE SIGNED <u>2/5/62</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE <u>2-6-62</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Brooking Cem.</u> | 23d. LOCATION (City, town, or county) (State) <u>RAYTOWN Mo.</u> |
| 24. FUNERAL DIRECTOR <u>Hinton Funeral Home</u> ADDRESS <u>Raytown, Mo.</u> | | 25. DATE RECD. BY LOCAL REG. <u>2-5-62</u> | 26. REGISTRAR'S SIGNATURE <u>Alla L. Craig</u> |

~~FEB 19 1962~~

US FEB 27 1962

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 Ernest D. Goldenow

Licensed Embalmer No. 4714

P. O. Address RCMO

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.