

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-005244
STATE FILE NUMBER

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 18

AMENDED

FILED FEB 6 1962

1. PLACE OF DEATH a. COUNTY <u>Vernon</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>Washington Twp.</u>		Length of stay in 1b <u>17y 3m 12da</u>	c. CITY OR TOWN <u>Kansas City</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>State Hosp # 3</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1005 Jefferson St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Paul</u> Middle <u>?</u> Last <u>Maikainai</u>			4. DATE OF DEATH Month <u>1</u> Day <u>29</u> Year <u>62</u>		
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5. SEX <u>M</u>	6. COLOR OR RACE <u>Yellow</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>6-9-03</u>	9. AGE (last birthday) <u>58</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HR Months _____ Days _____ Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nightwatch</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>unk</u>	11. BIRTHPLACE (City and state or country) <u>Honolulu, Hawaii</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>Paul Maikainai Sr</u>	13b. MOTHER'S MAIDEN NAME <u>unk</u>	14. NAME OF HUSBAND OR WIFE <u>Verle Maikainai</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>unk</u>	16. SOCIAL SECURITY NO. <u>unk</u>	17. INFORMANT <u>Records</u> Address <u>State Hospital # 3 Nevada, 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>Acute Coronary Occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>?</u>
DUE TO (b) <u>Arterio sclerosis.</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) <u>Chr. Brain Syndrome due to Syphilis-Meningoencephalitis</u>	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.)
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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 _____
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21. I attended the deceased from <u>7-1-57</u> to <u>1-29-62</u> and last saw him <u>passed his remains on</u> Death occurred at <u>6:25 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>J Combs</u> (Degree or title <u>MD</u>)	22b. ADDRESS <u>Nevada Mo</u>	22c. DATE SIGNED <u>1-29-62</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>1-29-1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Anatomical Board</u>	23d. LOCATION (City, town, or county) (State) <u>Washington Univ. St. Louis, Mo</u>
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24. FUNERAL DIRECTOR <u>FERRY FUNERAL HOME, NEVADA, MISSOURI</u>	25. DATE RECD. BY LOCAL REG. <u>2-3-1962</u>	26. REGISTRAR'S SIGNATURE <u>Anna E. Jurek</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 L. Anglen Ferry

Licensed Embalmer No. 4960

P. O. Address Nevada, Minn.

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.