

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**-62-005616**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 264

AMENDED **FILED MAR 12 1962**

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

3. NAME OF DECEASED (Type or print) First <b>Lony</b> Middle <b>Jean</b> Last <b>Kerns</b>			4. DATE OF DEATH Month <b>Feb.</b> Day <b>21,</b> Year <b>1962</b>		
---	--	--	---	--	--

5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb 21, 1962</b>	9. AGE (last birthday) <b>2</b>	IF UNDER 1 YEAR Months <b>2</b> Days <b>2</b>	IF UNDER 24 HR Hours <b>2</b> Min.
-------------------------	----------------------------------	---	---	------------------------------------	--	---------------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>no</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>no</b>	11. BIRTHPLACE (City and state or country) <b>St. Joseph, Mo</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
--	--	---	--

13a. FATHER'S NAME <b>Jack L. Kerns</b>	13b. MOTHER'S MAIDEN NAME <b>Betty Jean Gibson</b>	14. NAME OF HUSBAND OR WIFE <b>none</b>
--	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT <b>Jack L. Kerns, Agency Mo</b>	Address <b>14</b>
---	--	--	-------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fetal atelectasis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2hrs</b>
DUE TO (b) <b>prematurity (at 22 wks)</b>		
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. <input type="checkbox"/> Yes <input checked="" 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 <b>Agency Mo</b>	COUNTY _____ STATE _____
--	--	--	--------------------------

21. I attended the deceased from **2/21/62** to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_  
Death occurred at **2:30 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Scott Benson M.D.</b>	22b. ADDRESS <b>324 No 6th St. Joseph, Mo</b>	22c. DATE SIGNED <b>2/24/62</b>
--	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>2/23/62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Agency Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Joseph, Agency Mo</b>
--	-----------------------------	--	---

24. FUNERAL DIRECTOR <b>John Supp</b>	ADDRESS <b>St. Joseph, Mo</b>	25. DATE RECD. BY LOCAL REG. <b>Mar. 5, 1962</b>	26. REGISTRAR'S SIGNATURE <b>Mrs. Clark Goodell</b>
--	----------------------------------	---	--

(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 DATE AMENDED  
 INSTEAD OF  
 DOCUMENT  
 SHOULD READ  
 BY AFFIDAVIT OF

S.C. Benson, M.D.

**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,

      , Student Embalmer No.       

working under my personal supervision.

Student       

Signature of Student Embalmer

Signed       

*John E. Rupp*

Licensed Embalmer No. 3986

P. O. Address St. Joseph

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.