

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-011103

1834

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

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

FILED APR 16 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | |
| a. COUNTY Jackson | | a. STATE Missouri b. COUNTY Jackson | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City | | Length of stay in lb 31 Yrs | c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Swope Ridge Nursing Home | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 1021 W. 69th St. Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last Belle Ford Kennedy | | | 4. DATE OF DEATH Month Day Year March 31 1962 |
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 8-30-1869 |
| 9. AGE (last birthday) 92 Yrs | | IF UNDER 1 YEAR Months Days Hours | IF UNDER 24 HR Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home | | 10b. KIND OF BUSINESS OR INDUSTRY At Home | 11. BIRTHPLACE (City and state or country) Ayr, Ontario Canada |
| 12. CITIZEN OF WHAT COUNTRY USA | | 13a. FATHER'S NAME John Ford | |
| 13b. MOTHER'S MAIDEN NAME Jessie Stark | | 14. NAME OF HUSBAND OR WIFE W. Kennedy | |
| 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. None | 17. INFORMANT William H. McCrary Address 1021 W. 69th St. |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure | | | INTERVAL BETWEEN ONSET AND DEATH 3 day 2 |
| DUE TO (b) Arterio-sclerotic Heart Disease | | | 10 years |
| DUE TO (c) Senility | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I. Arterio-sclerotic aorta | | | 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 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. 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>1942</u> to <u>3-31-62</u> and last saw her alive on <u>3-30-62</u> Death occurred at <u>Swope Ridge Nursing Home</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) Don Carlos Pate md | | 22b. ADDRESS 1500 Prof. Blvd | 22c. DATE SIGNED 4-2-62 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 4-2-62 | 23c. NAME OF CEMETERY OR CREMATORY Elmwood | 23d. LOCATION (City, town, or county) (State) Kansas City, Missouri |
| 24. FUNERAL DIRECTOR Stine & McClure Kansas City, Missouri | | 25. DATE RECD. BY LOCAL REG. 4-2-62 | 26. REGISTRAR'S SIGNATURE Ruth Long |

USE BLACK INK OR TYPEWRITER RIBBON

Dr. Van Feste
V. 2-1145
1500 Professional Bldg

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 William M. Turner

Licensed Embalmer No. 4648

P. O. Address Kansas City, Mo.

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.