

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-011259

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1793

DO NOT WRITE ON THIS STUB

AMENDED

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

BY AFFIDAVIT OF

INSTEAD OF

DOCUMENT

Albert E. Fulton MEDICAL CERTIFICATION

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Jackson | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Kansas b. COUNTY Johnson | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City | | Length of stay in lb 2yrs | c. CITY OR TOWN Fairway Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Neurological Hospital | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 6219 Reinhardt Dr. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Herbert Middle C. Last Porter | | | 4. DATE OF DEATH Month 3 - Day 29 - Year 1962 |
| 5. SEX Male | 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 12-11-1879 AGE (last birthday) 84 IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Mangr. | | 10b. KIND OF BUSINESS OR INDUSTRY Gas Service Co. Faribault, Minn. | 12. CITIZEN OF WHAT COUNTRY U.S.A. |
| 13a. FATHER'S NAME Unknown | | 13b. MOTHER'S MAIDEN NAME Unknown | 14. NAME OF HUSBAND OR WIFE Harriett Porter |
| 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 Address John N. Porter 6219 Reinhardt dr. |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GENERAL ARTERIO SCLEROSIS | | | INTERVAL BETWEEN ONSET AND DEATH 7 3/4 YRS |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) CHRONIC BRAIN SYNDROME DUE TO CEREBRAL ARTERIO SCLEROSIS | | | 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 7/19/60 to 3/29/62 and last saw ^{her} _{him} alive on 3/28/62 Death occurred at 6:10 AM on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) Albert E. Fulton M.D. | | 22b. ADDRESS 2625 W. PASEO KANSAS CITY | 22c. DATE SIGNED 3/29/62 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 3-31-1962 | 23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery | 23d. LOCATION (City, town, or county) (State) St. Joseph, Missouri |
| 24. FUNERAL DIRECTOR ADDRESS Mellody-McGilley-Eylar 20 W. Linwood K.C. 11, Mo. | | 25. DATE RECD. BY LOCAL REG. 3-30-62 | 26. REGISTRAR'S SIGNATURE Ruth Long |

USE BLACK INK OR TYPEWRITER RIBBON

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 Wm H. Gentry

Licensed Embalmer No. 5038

P. O. Address K. C. 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.