

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-011480  
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1733

DO NOT WRITE ON THIS STUB

AMENDED

**FILED APR 5 1962**

VS 300  
Rev. 4/59

DATE AMENDED

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in 1b <b>30 yrs</b>	c. CITY OR TOWN <b>Kansas City</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Benton Rest Home</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>4226 Michigan</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Rachel</b> Middle <b>Alice</b> Last <b>Wilson</b>			4. DATE OF DEATH Month <b>March</b> Day <b>25</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 type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>3-23-1875</b>
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	9. AGE (last birthday) <b>87</b> IF UNDER 1 YEAR Months Days Hours Min.
11a. FATHER'S NAME <b>Martin Van Buren</b>		11b. MOTHER'S MAIDEN NAME <b>Unknown</b>	11. BIRTHPLACE (City and state or country) <b>Wichita, Kansas</b>
12a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		12b. SOCIAL SECURITY NO. <b>*****</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13a. FATHER'S NAME <b>Martin Van Buren</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	14. NAME OF HUSBAND OR WIFE <b>Joseph Wilson</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>*****</b>	17. INFORMANT <b>Ethel Holt</b> Address <b>319 Park K.C. Mo.</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>Cerebral Hemorrhage</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>hypertension</b> DUE TO (c) <b>arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>2 years</b> <b>10 years</b>
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 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 <b>1-5-62</b> to <b>3-25-62</b> and last saw her alive on <b>3-25-62</b> Death occurred at <b>11:50 AM</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Frank Paul Lawrence MD</b> (Degree or title)		22b. ADDRESS <b>428 So. White Ave</b>	22c. DATE SIGNED <b>3-25-62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>3-28-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Troy, Kansas</b>
24. FUNERAL DIRECTOR <b>C. H. Blackman &amp; Son Inc. K.C. Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>3-27-62</b>	26. REGISTRAR'S SIGNATURE <b>Ruth Long</b>

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 W.C. Bennett

Licensed Embalmer No. 4879

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.