

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-012197

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 275 Primary Registration District No. 3053 Registrar's No. 66

VS 300  
Rev. 4/59

1 0817

2 0810

3 2

4 0

5 1

6

7 1

8 2

9 4201

10

11

12 86-0

13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

<p><b>FILED APR 5 1962</b></p> <p>1. PLACE OF DEATH</p>		<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p>	
<p>a. COUNTY <u>Phelps</u></p>		<p>a. STATE <u>MO.</u> b. COUNTY <u>Phelps</u></p>	
<p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Tolla</u></p>		<p>Length of stay in 1b <u>17 days</u></p>	<p>c. CITY OR TOWN <u>ST. James</u></p>
<p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ME Farland Nursing Home</u></p>		<p>Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>d. STREET ADDRESS (If outside, give location) <u>✓</u></p>
<p>3. NAME OF DECEASED (Type or print) First Middle Last <u>William R. Kendall</u></p>			<p>4. DATE OF DEATH Month Day Year <u>3-25-62</u></p>
<p>5. SEX <u>male</u></p>	<p>6. COLOR OR RACE <u>white</u></p>	<p>7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <u>9-27-1870</u></p>
<p>9. AGE (last birthday) <u>91</u></p>	<p>IF UNDER 1 YEAR Months Days</p>	<p>IF UNDER 24 HR Hours Min.</p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u></p>		<p>10b. KIND OF BUSINESS OR INDUSTRY <u>✓</u></p>	<p>11. BIRTHPLACE (City and state or country) <u>Illinois</u></p>
<p>12. CITIZEN OF WHAT COUNTRY <u>USA</u></p>			
<p>13a. FATHER'S NAME <u>Do Not Know</u></p>		<p>13b. MOTHER'S MAIDEN NAME <u>Do Not Know</u></p>	<p>14. NAME OF HUSBAND OR WIFE <u>Clara Kendall</u></p>
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u></p>		<p>16. SOCIAL SECURITY NO. <u>✓</u></p>	<p>17. INFORMANT Address <u>Clara Kendall - St. James, MO.</u></p>
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:</p>			<p>INTERVAL BETWEEN ONSET AND DEATH <u>20 min</u></p>
<p>IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u></p>			
<p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____</p>			
<p>DUE TO (c) _____</p>			
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)</p>			<p>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</p>
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	<p>20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/></p>	<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)</p>	
<p>20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year</p>	<p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p>	<p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	<p>20f. CITY, TOWN, OR LOCATION COUNTY STATE</p>
<p>21. I attended the deceased from <u>3-8-62</u> to <u>3/25/62</u> and last saw <sup>her</sup>him alive on <u>March 24, 1962</u></p>			
<p>Death occurred at <u>6:30 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.</p>			
<p>22a. SIGNATURE (Degree or title) <u>Dr. Anderson</u></p>		<p>22b. ADDRESS <u>Rolla Mo</u></p>	<p>22c. DATE SIGNED <u>3/25/62</u></p>
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></p>	<p>23b. DATE <u>3-27-62</u></p>	<p>23c. NAME OF CEMETERY OR CREMATORY <u>Masonic Cem.</u></p>	<p>23d. LOCATION (City, town, or county) <u>ST. James, MO.</u></p>
<p>24. FUNERAL DIRECTOR ADDRESS <u>Prof. E. L. Liddell - St. James, Mo</u></p>		<p>25. DATE RECD. BY LOCAL REG. <u>Mar. 26, 1962</u></p>	<p>26. REGISTRAR'S SIGNATURE <u>Nadine L. Stoll</u></p>

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 ME, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student: \_\_\_\_\_

Signature of Student Embalmer

Signed Orval E. Lickliss

Licensed Embalmer No. 3546

P. O. Address 77 1/2 1st St

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.