

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-015384  
2253 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2253

**FILED MAY 14 1962**

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF  
Robert L. Ward

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>Jackson</u>		a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		c. CITY OR TOWN <u>Kansas City</u>	
Length of stay in 1b <u>life</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Mary's Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>437 N. Quincy</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH
First <u>RAYMOND</u> Middle <u>HERSHAL</u> Last <u>NORTH</u>			Month <u>April</u> Day <u>22</u> Year <u>1962</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4-8-1893</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired--</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>American Railroad Express</u>	9. AGE (last birthday) <u>69</u>
11a. FATHER'S NAME <u>Webster North</u>		11b. MOTHER'S MAIDEN NAME <u>Leota Hollingsworth</u>	11. BIRTHPLACE (City and state or country) <u>Kansas City, Missouri</u>
12a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		12b. SOCIAL SECURITY NO. <u>none</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>
13. FATHER'S NAME		14. NAME OF HUSBAND OR WIFE <u>Elizabeth North</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. P. C. McNellis</u>		Address <u>437 N. Quincy</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>			<u>7 days.</u>
DUE TO (b) <u>Arteriosclerotic Heart Disease</u>			<u>?</u>
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Pulmonary Emphysema</u>			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"/>	20b. SUICIDE <input type="checkbox"/>	20c. HOMICIDE <input type="checkbox"/>
20d. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour _____ 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>4-15-62</u> to <u>4-22-62</u> and last saw him alive on <u>4-22-62</u>			
Death occurred at <u>7:00</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Robert L. Ward, M.D.</u>		22b. ADDRESS <u>4126 St John</u>	
22c. DATE SIGNED <u>4-23-62</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>4-25-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		23d. LOCATION (City, town, or county) <u>Kansas City, Kansas</u>	
24. FUNERAL DIRECTOR <u>Melody-McGilley-Eylar</u>		ADDRESS <u>Woodland</u>	
25. DATE RECD. BY LOCAL REG. <u>4-24-62</u>		26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>	

Dr. Robert Grand  
4126 St. John  
Nu 3-3119

Mon: 1:00 to 5:00

**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

*Robert G. Landes*

Licensed Embalmer No. 5103

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.