

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**62-015464**

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2338

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

1

2 3759

3

4 1

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7 1

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9 9040

10 21

11 123

12 640

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

Frank B. Leitz

1. <b>FILED DEATH MAY 14 1962</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <b>JACKSON</b>		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 lb <b>40 YEARS</b>	c. CITY OR TOWN <b>KANSAS CITY</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>RESEARCH HOSPITAL</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>4909 TROOST AVENUE</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED First Middle Last <b>DELLA M SHRIVER</b>			4. DATE OF DEATH Month Day Year <b>APRIL 26th 1962</b>
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>CAUCASIAN</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>10/26/73</b>
9. AGE (last birthday) <b>88</b>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AT HOME</b>		10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (City and state or country) <b>ALLERTON, IOWA</b>
12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>		13. FATHER'S NAME <b>MARCELLUS BROWN</b>	
14. MOTHER'S MAIDEN NAME <b>REBECCA LILY</b>		14. NAME OF HUSBAND OR WIFE <b>THOMAS B. SHRIVER</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>NONE</b>	17. INFORMANT <b>MRS. FLOY SMITH</b> Address <b>4909 TROOST AVE. KANSAS CITY, 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>Congestive Heart Failure</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Hypertensive arteriosclerotic heart disease, 10+ years</b> DUE TO (c) <b>Rt hip nail injury fracture femur</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH 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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <b>Fell in the home 4-8-62</b>	
20c. TIME OF INJURY Hour Month, Day, Year <b>4-8-62</b>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. CITY, TOWN, OR LOCATION COUNTY STATE <b>Kansas City Jackson Mo.</b>	
21. I attended the deceased from <b>4-10-62</b> to <b>4-26-62</b> and last saw her alive on <b>4-26-62</b> Death occurred at <b>8.00 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Frank B. Leitz MD</b>		22b. ADDRESS <b>1530 P. W. Pk Kansas City Mo</b>	22c. DATE SIGNED <b>4-27-62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>4-28-62</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>FOREST HILL CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>KANSAS CITY MISSOURI</b>
24. FUNERAL DIRECTOR <b>D. W. NEWCOMER'S SONS, KANSAS CITY MO</b>		25. DATE RECD. BY LOCAL REG. <b>4-28-62</b>	26. REGISTRAR'S SIGNATURE <b>Ruth Long</b>

Dr. Charles E. Velvick  
1600 Proglumene Road  
2:00-4:00

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 James W. Lawson

Licensed Embalmer No. 4889

P. O. Address Lathrop, 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.