

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-015538

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2002

FILED APR 20 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (if outside corporate limits, give TOWNSHIP only) <u>Kansas City</u>		Length of stay in 1b <u>57 yrs.</u>	c. CITY OR TOWN <u>Kansas City</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. Joseph Hosp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1100 E 9th.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>CALVIN</u> Last <u>WELLS</u>			4. DATE OF DEATH Month <u>APRIL</u> Day <u>9</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>9-21-1884</u>
9. AGE (last birthday) <u>77</u>		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) <u>Shipping</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Conn Products</u>	11. BIRTHPLACE (City and state or country) <u>Hardin, Mo</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME _____ 13b. MOTHER'S MAIDEN NAME _____	
14. NAME OF HUSBAND OR WIFE _____		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. _____		17. INFORMANT <u>MAURICE Wells - 456 No. 18 St. K.C., Kan</u> Address _____	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO (b) <u>Essential Hypertension</u> DUE TO (c) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>15 days</u> <u>unknown</u> <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cholelithiasis - Pyloric Obstruction</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"/> 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 <u>3-21-62</u> to <u>4-9-62</u> and last saw him alive on <u>4-9-62</u> Death occurred at <u>10:30</u> <u>P</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>M.F. Sewell</u> (Degree or title) <u>M.D.</u>		22b. ADDRESS <u>1722 W 39 K.C. Mo</u>	
22c. DATE SIGNED <u>4-10-62</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>4-12-1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope</u>		23d. LOCATION (City, town, or county) (State) <u>Kansas City, Kansas</u>	
24. FUNERAL DIRECTOR <u>C.H. Blackman & Son Inc.</u>		25. DATE RECD. BY LOCAL REG. <u>4-10-62</u>	
ADDRESS <u>K.C., Mo.</u>		26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>	

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 Robert B. Baird

Licensed Embalmer No. 4888

P. O. Address KC 24, 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.