MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

62-015589
STATE FILE NUMBER

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 191

FILED APR 24 1962

DO NOT WRITE ON THIS STUB — AMENDED

VS 300 Rev. 4/59

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO.	SHOULD READ	INSTEAD OF	DATE AMENDED
1	7005		
2	7005		
3			
4	0		
5	2		
6			
7	1		
8	1		
9	441X		
10			
11			
12	1-0		
13	1-0		

USE BLACK INK OR TYPEWRITER RIBBON

BY AFFIDAVIT OF DOCUMENT

1. PLACE OF DEATH
a. COUNTY: Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Independence — Length of stay in 1b: 12 yrs
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Independence Hosp — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo — b. COUNTY: Jackson
c. CITY OR TOWN: Independence — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 210 E Lexington — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Josephus — Middle: L — Last: Haddock

4. DATE OF DEATH: Month: April — Day: 16 — Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐

8. DATE OF BIRTH: 2-24-85

9. AGE (last birthday): 77 — 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): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Farmer

11. BIRTHPLACE (City and state or country): Charlotte Ark.

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: William Haddock

13b. MOTHER'S MAIDEN NAME: Alecia Foster

14. NAME OF HUSBAND OR WIFE: Martha A. Haddock

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Unknown — (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: unknown

17. INFORMANT: J. D. Haddock — Address: 628 Sunrise Drive, Indep. Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Subrachnoid hemorrhage, left posterior cerebral artery. — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Hypertensive cardiovascular disease (malignant) — undetermined
DUE TO (c): Generalized arteriosclerosis.

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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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 ☐ NOT WHILE AT WORK ☐

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 April 15, 1962, to 4/16/62 and last saw her/him alive on 4/16/62

Death occurred at 12:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Dallas B. Fouts Jr. MD

22b. ADDRESS: 10901 Winner Road, Independence, Mo.

22c. DATE SIGNED: 4-17-62

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 4-19-1962

23c. NAME OF CEMETERY OR CREMATORY: Memorial Park

23d. LOCATION (City, town, or county) (State): Kansas City Mo

24. FUNERAL DIRECTOR: Shull Funeral Home — ADDRESS: K.C. Mo

25. DATE RECD. BY LOCAL REG.: 4-17-62

26. REGISTRAR'S SIGNATURE: Alba L. Craig

(Licensed Embalmer's Statement on Reverse Side)

Dr. Foutz
10801 E Winner Rd.

APR 25 1962

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 Thomas A. Shiel

Licensed Embalmer No. 4954

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.