

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-017890

STATE FILE NUMBER

Registration District No. 4 Primary Registration District No. _____ Registrar's No. 43

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1 0030
2 0440
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4 0
5 1
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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

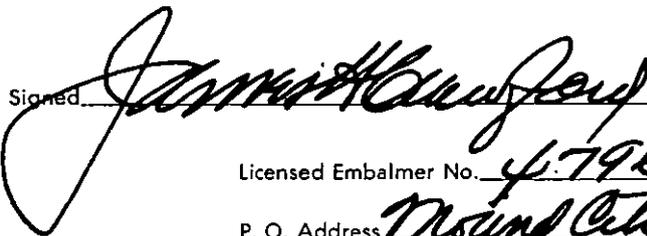
1. PLACE OF DEATH a. COUNTY ATCHISON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI COUNTY HOLT	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN FAIRFAX		Length of stay in lb 2 DAYS	c. CITY OR TOWN MOUND CITY
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION COMMUNITY HOSP.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location)
3. NAME OF DECEASED (Type or print) First Middle Last JOHN HERMAN KINNEY			4. DATE OF DEATH Month Day Year MAY 12 1962
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12/18/1896
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING	9. AGE (last birthday) 65
11. BIRTH PLACE (City and state or country) HOLT COUNTY, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME WILLIAM A. KINNEY		13b. MOTHER'S MAIDEN NAME CATHERINE BUNTZ	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. [REDACTED]	
17. INFORMANT MAX KINNEY, Council Bluffs IA		Address	
18. CAUSE OF DEATH (Enter only one cause per line. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary arrest			INTERVAL BETWEEN ONSET AND DEATH 4 min.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Periparturinary respiratory collapse			4 min.
DUE TO (c) Myocardial infarction			day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) MIAC infarct 3 days			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 _____ e.m. _____ p.m. _____	Month, Day, Year _____		
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.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from July 19, 59 to May 12, 62 and last saw him alive on May 12, 1962 Death occurred at 6 P m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) James H. Crawford M.D.		22b. ADDRESS Mound City, Mo.	22c. DATE SIGNED May 15, 1962
23a. BURIAL, CREMATION, or DISPOSAL (Specify) BURIAL	23b. DATE 5/15/1962	23c. NAME OF CEMETERY OR CREMATORY MOUNT HOPE	23d. LOCATION (City, town, or county) (State) MOUND CITY, MO.
24. FUNERAL DIRECTOR James H. Crawford	ADDRESS Mound City, Mo.	25. DATE RECD. BY LOCAL REG. May 19, 1962	26. REGISTRAR'S SIGNATURE Marvin N. Schaefer

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  _____
Licensed Embalmer No. 4796
P. O. Address Moind City, 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.