

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-019104

2440

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2440

FILED MAY 31 1962

VS 300
Rev. 4/59

1

2 748

3

4 1

5 2

6

7 1

8 0

94222

10

11

1290-0

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY JACKSON		a. STATE MISSOURI COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		c. CITY OR TOWN KANSAS CITY	
Length of stay in lb 50 YEARS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4828 HARRISON STREET		d. STREET ADDRESS (If outside, give location) 4828 HARRISON STREET	
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 ZELLA Middle OLIVE Last SAUNDERS		Month APRIL Day 30 Year 1962	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9/23/82
9. AGE (last birthday) 80		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) AT HOME - OPERATOR		10b. KIND OF BUSINESS OR INDUSTRY NEEDLEWORK SHOP	11. BIRTHPLACE (City and state or country) LINN COUNTY, KANSAS U. S. A.
12. CITIZEN OF WHAT COUNTRY		13. NAME OF HUSBAND OR WIFE GEORGE M. SAUNDERS	
13a. FATHER'S NAME ALBERT HODGSON		13b. MOTHER'S MAIDEN NAME ELIZABETH	
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. NONE	
17. INFORMANT CARY HODGSON		Address KINCAID, KANSAS	
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) Quelovry Embolism			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			
DUE TO (b) Chronic Myocardial			
DUE TO (c) Hernial Diaphragm			
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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 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>1954</u> to <u>Apr 30 1962</u> and last saw her alive on <u>1045 am Apr 30 62</u>		Death occurred at <u>3:26 P.</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) B. W. Sharp M.D.		22b. ADDRESS 1099 E - 47th St	
22c. DATE SIGNED 5-1-62			
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE MAY 4, 1962	23c. NAME OF CEMETERY OR CREMATORY PARKER CEMETERY	
23d. LOCATION (City, town, or county) PARKER KANSAS			
24. FUNERAL DIRECTOR D. W. NEWCOMER'S SONS		25. DATE RECD. BY LOCAL REG. 5-4-62	
ADDRESS 1331 BRUSH CR. KANSAS CITY, MO.		26. REGISTRAR'S SIGNATURE Ruth Long	

USE BLACK INK OR TYPEWRITER RIBBON

Dr. B. W. Sharp
1009 East 4th Street
11:30 - 5:30

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 W. Polson

Licensed Embalmer No. 4889

P. O. Address Father, 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.