

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-019149

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2460

DO NOT WRITE ON THIS STUB

AMENDED

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF  
Albert I. Decker  
MEDICAL CERTIFICATION

<b>FILED MAY 31 1962</b>		1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <b>Jackson</b>		b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Kansas City</b>		a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Kansas City</b>		Length of stay in 1b <b>6 Days</b>		c. CITY OR TOWN <b>St Joseph</b>	
c. FULL NAME OF (IF NOT in hospital, give location) <b>St Joseph Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>1201 Sylvania</b>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH		5. YEAR	
First <b>THELMA</b> Middle <b>MORINE</b> Last <b>WARD</b>		Month <b>May</b> Day <b>4</b>		Year <b>1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>6-20-1910</b>	9. AGE (last birthday) <b>51</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dental Ass't</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dentist</b>		11. BIRTHPLACE (City and state or country) <b>Amazonia, Missouri</b>	
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13a. FATHER'S NAME <b>William Knapp Crafton</b>		13b. MOTHER'S MAIDEN NAME <b>Mabel Clara Babb</b>	
14. NAME OF HUSBAND OR WIFE <b>—</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, (op. or unknown)) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs Patricia Matkin 8408 E. 110th St.</b>		Address <b>K.C., Mo</b>		18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY:	
IMMEDIATE CAUSE (a) <b>Uremia</b>		DUE TO (b) <b>Chronic glomerulonephritis</b>		DUE TO (c) <b>—</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>—</b>		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		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>Unknown</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" 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.) <b>—</b>			
20c. TIME OF INJURY Hour a.m. p.m. <b>—</b>	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.) <b>—</b>	20f. CITY, TOWN, OR LOCATION <b>—</b>	20g. COUNTY <b>—</b>	20h. STATE <b>—</b>
21. I attended the deceased from <b>May 1, 1962</b> to <b>May 3, 1962</b> and last saw her alive on <b>May 3, 1962</b> Death occurred at <b>3:15 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>Albert I. Decker</b>		22b. ADDRESS <b>Kansas City, Mo.</b>		22c. DATE SIGNED <b>5-4-62</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>MAY 5, 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>—</b>	
23d. LOCATION (City, town, or county) <b>ST JOSEPH, MISSOURI</b>		24. FUNERAL DIRECTOR <b>Heaton-Bowman Funeral Home</b>		25. DATE RECD. BY LOCAL REG. <b>5-5-62</b>	
26. REGISTRAR'S SIGNATURE <b>Ruth Long</b>		27. ADDRESS <b>St Joseph, MO.</b>			

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 John R. Sidman

Licensed Embalmer No. 4531

P. O. Address Kansas 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.