

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-019223  
STATE FILE NUMBER

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 248

DO NOT WRITE ON THIS STUB

AMENDED

**FILED MAY 22 1962**

VS 300  
Rev. 4/59

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26000

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Clay</u>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Independence</u>		Length of stay in lb <u>2 da</u>	c. CITY OR TOWN <u>Liberty</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Grady Sanitarium</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) <u>R. 3</u> Residence on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOE AARON MAYNARD</u>			4. DATE OF DEATH Month Day Year <u>May 15 - 62</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5-13-62</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE (last birthday) IF UNDER 1 YEAR IF UNDER 24 HR Months <u>0</u> Days <u>2</u> Hours <u>0</u> Min. <u>0</u>
11a. BIRTHPLACE (City and state and country) <u>Independence Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Joe H. Maynard</u>		13b. MOTHER'S MAIDEN NAME <u>Rilla M. Johnson</u>	14. NAME OF HUSBAND OR WIFE <u>None</u>
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. <u>None</u>	17. INFORMANT <u>Joe H. Maynard</u> Address <u>Liberty Mo.</u>
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>Erythrablastosis Fetalis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 da.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
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 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 _____ s.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 <u>5-13-62</u> to <u>5-15-62</u> and last saw him alive on <u>5-15-62</u> Death occurred at <u>1:30 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Signature or title) <u>William L. Cox MD</u>		22b. ADDRESS <u>Liberty Mo</u>	22c. DATE SIGNED <u>5-16-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>5-16-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Hope</u>	23d. LOCATION (City, town, or county) (State) <u>Liberty Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Church-Decker Co. Liberty Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>5-16-62</u>	26. REGISTRAR'S SIGNATURE <u>Alba L. Craig</u>

**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 Jane Lombard

Licensed Embalmer No. 4448

P. O. Address Liberty 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.