

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-022266

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 59

Primary Registration District No. _____

Registrar's No. 118

FILED JUL 10 1962

VS 300
Rev. 4/59

1 0190
2 01922

3
4 0
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7 0
8 2
9 4201
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11
12 86-2
13 1-0

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Cass</u>		2. USUAL RESIDENCE (Where deceased lived. Institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cass</u>	
b. CITY (If outside corporate limits, give TOWNSHIP or TOWN) <u>Peculiar Twp</u> Length of stay in lb <u>6 days</u>		c. CITY OR TOWN <u>Harrisonville</u> Inside Limits: Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Pleasant View Rest Home</u> Inside Limits: Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>604 Short St.</u> Reside on Farm: Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>LINDSAY</u> Last _____		4. DATE OF DEATH Month <u>July</u> Day <u>3</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</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>4-27-1894</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cass Co Mo. USA</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>William A Lindsay</u>		14. NAME OF HUSBAND OR WIFE <u>Walter S. Heid Harrisonville Mo.</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>		17. INFORMANT <u>Walter S. Heid Harrisonville Mo.</u> Address _____	
16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address _____	
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>Coronary thrombosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Atherosclerosis</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
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 _____ a.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>8:00 AM June 28</u> to <u>July 3</u> and last saw him alive on <u>July 3, 1962</u> . Death occurred at <u>4:15 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>J. E. Frasch MD</u> (Degree or title)		22b. ADDRESS <u>Harrisonville Mo</u>	22c. DATE SIGNED <u>7/3/62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>July 5 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Orient Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Harrisonville Mo.</u>
24. FUNERAL DIRECTOR <u>Bunnenburg Harrisonville Mo</u> ADDRESS _____	25. DATE RECD. BY LOCAL REG. <u>July 3-1962</u>	26. REGISTRAR'S SIGNATURE <u>Miss Ray Sabree</u>	

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 Frank E. Runnenbryer ³²

Licensed Embalmer No. 5073

P. O. Address Harrisonville, 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.