

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-023298
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3316

FILED JUL 16 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS (INSTEAD OF)

ITEM NO. SHOULD READ

DOCUMENT

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI COUNTY ST CLAIR	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Length of stay in lb 7 DAYS	c. CITY OR TOWN OSCEOLA KANSAS-CITY Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST LUKES HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) R.F.D. Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First CLAUDE Middle C Last MULKEY			4. DATE OF DEATH Month JUNE Day 21st Year 1962
5. SEX MALE	6. COLOR OR RACE CAUCASIAN	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3/10/08
9. AGE (last birthday) 54	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.	12. CITIZEN OF WHAT COUNTRY U.S.A
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER		10b. KIND OF BUSINESS OR INDUSTRY BOY SCOUT CAMP HARPER	11. BIRTHPLACE (City and state or country) MISSOURI
13a. FATHER'S NAME MARION MULKEY		13b. MOTHER'S MAIDEN NAME SALLY CHILES	14. NAME OF HUSBAND OR WIFE VERGIE MULKEY OSCEOLA MO
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO NONE		17. INFORMANT VERGIE OSCEOLA MISSOURI 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) Intracerebral Hemorrhage			INTERVAL BETWEEN ONSET AND DEATH 8 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Unknown			
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 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 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>6-14-62</u> to <u>6-21-62</u> and last saw her/him alive on <u>6-21-62</u> Death occurred at <u>9.45 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Robert W. Langthorn		22b. ADDRESS 4820 Wornall Rd.	22c. DATE SIGNED 6-21-62
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 6-21-62	23c. NAME OF CEMETERY OR CREMATORY OSCEOLA CEMETERY	23d. LOCATION (City, town, or county) (State) OSCEOLA MISSOURI
24. FUNERAL DIRECTOR D.W. Newcomer's Sons Kansas City Mo	ADDRESS 1331 Brush Creek Blvd.	25. DATE RECD. BY LOCAL REG. 6-23-62	26. REGISTRAR'S SIGNATURE Ruth A. Long

USE BLACK INK OR TYPEWRITER RIBBON

DR. ROBERT W. FOREYRKE
121239 TIME KIDG.
JE 1-3305
Hans. EN. 2-02982
04457 - Verona Rd, Residence
Shawnee - Missouri

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 _____ Signed _____
Signature of Student Embalmer

Licensed Embalmer No. _____
P. O. Address _____

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.