

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-023372

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2965

FILED JUN 25 1962

VS 300
Rev. 4/59

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2 3088
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7 0
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9 4331
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF J.M. Powers MEDICAL CERTIFICATION

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Length of stay in 1b 40 YEARS	c. CITY OR TOWN KANSAS CITY Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3833 THOMPSON AVENUE		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 3833 THOMPSON AVENUE Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last ELLA. M. RINARD			4. DATE OF DEATH Month Day Year MAY 31st 1962
5. SEX FEMALE	6. COLOR OR RACE CAUCASIAN	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 5-3-82
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	9. AGE (last birthday) 80 IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.
11a. FATHER'S NAME SAMUEL. M. MAYS		11b. MOTHER'S MAIDEN NAME ERMINE BAYLISS	11. BIRTHPLACE (City and state or country) SPARTA MISSOURI
12a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) NO		12b. SOCIAL SECURITY NO. NONE	12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME SAMUEL. M. MAYS		13b. MOTHER'S MAIDEN NAME ERMINE BAYLISS	14. NAME OF HUSBAND OR WIFE RODNEY. H. RINARD
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	17. INFORMANT VESTER MAYS Address 2909 EAST 29TH ST. KANSAS CITY, MO.
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>Hypostatic Broncho Pneumonia</u> Conditions, if any, which gave rise to above cause (a), starting the underlying cause last. DUE TO (b) <u>Auricular Fibrillation Acute</u> DUE TO (c) <u>arterio Sclerosis Generalized</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>1 week</u> <u>several years.</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 Month, Day, Year a.m. p.m.		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>May 15</u> to <u>May 31</u> and last saw her <u>5/31/62</u> alive on Death occurred at <u>2.00 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>John M Powers, M.D.</i> (Degree or title)		22b. ADDRESS <u>3304 Linwood Blvd</u>	22c. DATE SIGNED <u>6/1/62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE JUNE 4, 1962	23c. NAME OF CEMETERY OR CREMATORY MT. MORIAH CEMETERY	23d. LOCATION (City, town, or county) (State) KANSAS CITY MISSOURI
24. FUNERAL DIRECTOR D.W. Newcomer; s Sons Kansas City Mo		25. DATE RECD. BY LOCAL REG. <u>6-4-62</u>	26. REGISTRAR'S SIGNATURE <i>Rueh N Long</i>

Dr. John Miller Fowler's
330 4 Linwood Blvd
1:00-5:00

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 Wern Lawler

Licensed Embalmer No. 4915

P. O. Address K. C. 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.