

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

62-025498

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 1755

FILED JUN 20 1962

VS 300  
Rev. 4/59

4002

28150

3

4 0

5 1

6

7 0

8 2

9976X

10

11

1245-3

13

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <b>St. Louis.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Kansas</b> b. COUNTY <b>Johnson</b>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>Clayton, Mo.</b>		Length of stay in 1b <b>2 1/2 hrs.</b>	c. CITY OR TOWN <b>Overland Park</b>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Louis County Hospital</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>Overland Park</b>
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>D.</b> Last <b>James</b>		4. DATE OF DEATH Month <b>June</b> Day <b>11</b> Year <b>1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>2/27/1901</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shoe Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	9. AGE (last birthday) <b>61</b>
13a. FATHER'S NAME <b>Max James</b>		13b. MOTHER'S MAIDEN NAME <b>Jennie (Unknown)</b>	11. BIRTHPLACE (City and state or country) <b>St. Joseph, Missouri, U.S.A.</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No. Nil.</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
17. INFORMANT <b>Mrs. Oscar Jacobs, Overland Park, Kansas.</b>		14. NAME OF HUSBAND OR WIFE <b>Georgia</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot wound of head</b>			INTERVAL BETWEEN ONSET AND DEATH
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 checked="" 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>Self inflicted gunshot wound of head</b>	
20c. TIME OF INJURY Hour <b>between 8 &amp; 11</b> a.m. <b>6/11/62</b> 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.) <b>bedroom of friend's home</b>	20f. CITY, TOWN, OR LOCATION <b>St. John</b>	COUNTY <b>St. Louis</b> STATE <b>Missouri</b>
21. I attended the deceased from _____, to _____ and last saw her/him alive on _____ Death occurred at <b>1:40 P.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>[Signature]</i> (Degree or title) <b>Coroner</b>		22b. ADDRESS <b>Clayton, Missouri</b>	22c. DATE SIGNED <b>6/15/62</b>
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>6-13-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mount Moriah Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Kansas City, Mo.</b>
24. FUNERAL DIRECTOR <b>Albert H. Hoppe Inc., 4700 Washington, Blvd.</b>		25. DATE RECD. BY LOCAL REG. <b>6-13-62</b>	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>

**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 Harvey Kahle

Licensed Embalmer No. 4596

P. O. Address St Louis, 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.