

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

62-025770

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 94

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED JUN 26 1962

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

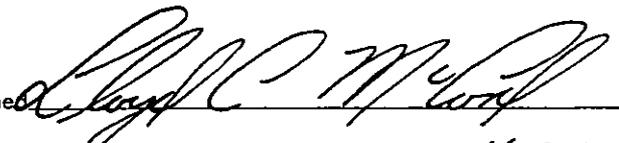
USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>Vernon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Washington Township</u>		Length of stay in 1b <u>3yr 4mo</u>	c. CITY OR TOWN <u>Kansas City</u>
c. FULL NAME OF (If NOT in hospital, give location), HOSPITAL OR INSTITUTION <u>State Hospital #3</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>New Market Hotel</u>
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>E.</u> Last <u>Chiles</u>		4. DATE OF DEATH Month <u>June</u> Day <u>19</u> Year <u>1962</u>	
5. SEX <u>Female</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>2-3-82</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>registered nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Medicine</u>	11. BIRTHPLACE (City and state or country) <u>Jackson County, Mo</u>
13a. FATHER'S NAME <u>William Gennings Chiles</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Emily Murfee</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 Address <u>hospital records</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u>			<u> yrs</u>
DUE TO (b) <u>Arteriosclerosis generalized</u>			<u> yrs</u>
DUE TO (c) <u>senility</u>			<u> yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Chronic brain syndrome associated w circulatory disturbance w cerebral arteriosclerosis w behavioral reaction</u>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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"/>
20c. TIME OF INJURY Hour _____ Month, Day, Year _____		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) _____	
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>December 9, '58</u> to <u>6-19-62</u> and last saw her <u>alive</u> on <u>6-19-62</u>			
Death occurred at <u>8:00 P</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>E. C. Quirk, MD</u>		22b. ADDRESS <u>State Hospital #3, Nevada</u>	22c. DATE SIGNED <u>6-19-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>6/20/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>6 Mile</u>	23d. LOCATION (City, town, or county) (State) <u>Jackson Co. Missouri</u>
24. FUNERAL DIRECTOR ADDRESS <u>Geo. C. Carson, Independence, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>6-23-1962</u>	26. REGISTRAR'S SIGNATURE <u>Anna E. Perry</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  _____

Licensed Embalmer No. 4853

P. O. Address Florida 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.