

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-027018 ✓

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3689

FILED JUL 30 1962

VS 300 Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

Walter H. Owens Medical Certification

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 10 Years	c. CITY OR TOWN INDEPENDENCE, Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VA Hospital, K.C., Mo.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 16500 E. 23rd St. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First JAMES Middle NATHAN Last COMBS			4. DATE OF DEATH Month July Day 13 Year 1962
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3-10-92
9. AGE (last birthday) 70		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STEAMFITTER-RETIRED		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) CRAIG, MISSOURI
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME JACOB N. Combs	
13b. MOTHER'S MAIDEN NAME CARRIE B. PERKINS		14. NAME OF HUSBAND OR WIFE MILDRED Combs	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW I		17. INFORMANT Address Official Records VA Hospital, K.C., Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: thrombosis of basilar artery with infarction of brain stem. IMMEDIATE CAUSE (a) _____ DUE TO (b) Generalized arteriosclerosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
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 checked="" 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 VA July 12, 1962 to July 13, 1962 Death occurred at 1:20 A. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Walter H. Owens		22b. ADDRESS VA Hospital, K.C., Mo.	
22c. DATE SIGNED 7-13-62		(State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 7-16-62	
23c. NAME OF CEMETERY OR CREMATORY OAK RIDGE MEMORY GARDENS		23d. LOCATION (city, town, or county) INDEPENDENCE, MO.	
24. FUNERAL DIRECTOR GEO. C. CARSON & SONS, INDEPENDENCE, MO.		25. DATE RECD. BY LOCAL REG. 7-15-62	
26. REGISTRAR'S SIGNATURE Ruth N Long			

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 Leroy J. Tyler

Licensed Embalmer No. 4941

P. O. Address Independence 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.