

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-027112 ✓

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3471

DO NOT WRITE ON THIS STUB

AMENDED

FILED JUL 25 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

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>Jackson</u>		a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		c. CITY OR TOWN <u>Raytown</u>	
Length of stay in lb <u>38 Yrs</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Blue Ridge Nursing Home</u>		d. STREET ADDRESS (If outside, give location) <u>11120 E. 57th Street</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First <u>Lillie</u> Middle <u>K.</u> Last <u>Hale</u>		Month <u>July</u> Day <u>2</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 type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>July 29, 1882</u>
9. AGE (last birthday) <u>79 Yrs</u>		IF UNDER 1 YEAR Months <u>7</u> Days <u>9</u>	IF UNDER 24 HR Hours <u>5</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (City and state or country) <u>Cooper Co. Missouri</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Louis Kloeckner</u>	
13b. MOTHER'S MAIDEN NAME <u>Rose Maas</u>		14. NAME OF HUSBAND OR WIFE <u>Oliver M. Hale</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>   <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Kenneth O. Hale</u>		Address <u>11120 E. 57th Street</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>Hypostatic pneumonia</u>			<u>60 hrs.</u>
DUE TO (b) <u>Congestive heart failure</u>			<u>4 days</u>
DUE TO (c) <u>Atherosclerosis.</u>			<u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Senility</u>			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>4/25/61</u> to <u>7/2/62</u> and last saw her alive on <u>7/2/62</u> Death occurred at <u>120</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Do not use title) <u>Dr. R. Hoffman, D.O.</u>		22b. ADDRESS <u>9140 E. Sotherway K.C. 33, Mo.</u>	
22c. DATE SIGNED <u>7/2/62</u>		23. LOCATION (City, town, or county) (State) <u>California, Missouri</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>7-2-62</u>	23c. NAME OF CEMETERY OR CREMATORY	
24. FUNERAL DIRECTOR ADDRESS <u>Stine &amp; McClure Kansas City, Missouri</u>		25. DATE RECD. BY LOCAL REG. <u>7-2-62</u>	26. REGISTRAR'S SIGNATURE <u>Ruth N Long</u>

USE BLACK INK OR TYPEWRITER RIBBON

*Dr. J. J. J. J. J.*  
9140 E. 50th St  
Call 7:00 P.M. 7-2-62

**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 *William M. Turner*

Licensed Embalmer No. 4648

P. O. Address Lawrence City, 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.