

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-027148

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3741 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED AUG 2 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

Ruth E. Yohe

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lafayette</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Length of stay in 1b <u>14 das</u>	c. CITY OR TOWN <u>Concordia</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Children's Mercy</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>RR #2</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Shirley Ann Hinck</u>			4. DATE OF DEATH Month Day Year <u>7-17-62</u>
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIAGE STATUS Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7-20-54</u>
9. AGE (last birthday) <u>7 Yrs.</u>		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) <u>child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>child</u>	11. BIRTHPLACE (City and state or country) <u>Lexington, Mo</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13. FATHER'S NAME <u>Hobert Hinck</u>	
14. MOTHER'S MAIDEN NAME <u>Tehma Brunkhorst</u>		15. NAME OF HUSBAND OR WIFE <u>Child</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Child</u>		17. SOCIAL SECURITY NO. <u>Child</u>	18. INFORMANT <u>Hobert Hinck RR #2 Concordia, Mo</u>
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>Septicemia</u>			
DUE TO (b) <u>Lymphocytic Leukemia</u>			
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 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 <u>7-3-62</u> to <u>7-17-62</u> and last saw her ^{her} alive on <u>7-17-62</u> Death occurred at <u>8:25 pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Ruth E. Yohe M.D.</u>		22b. ADDRESS <u>1710 Independence Ave KC Mo</u>	22c. DATE SIGNED <u>7-17-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>7-20-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Paul's</u>	23d. LOCATION (City, town, or county) (State) <u>Concordia Mo.</u>
24. FUNERAL DIRECTOR <u>Wagner Funeral Home, K.C. Mo</u>	25. DATE RECD. BY LOCAL REG. <u>7-18-62</u>	26. REGISTRAR'S SIGNATURE <u>Ruth E. Yohe</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 Alvin R. Hauscheld

Licensed Embalmer No. 4159

P. O. Address W. C. M. O.

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.

[Faint handwritten notes and signatures at the bottom of the page]