

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-027218

STATE FILE NUMBER

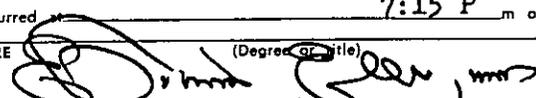
Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3921

DO NOT WRITE ON THIS STUB

AMENDED

FILED AUG 13 1962

VS 300	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	DATE AMENDED
Rev. 4/59		
1		
2 <u>3/178</u>		
3		
4 <u>2</u>		
5 <u>2</u>		
6		
7 <u>1</u>		
8 <u>2</u>		
9 <u>331X</u>		
10		
11		
12 <u>57-0</u>		
13		
	INSTEAD OF	
	DOCUMENT	
	MEDICAL CERTIFICATION	
	BY AFFIDAVIT OF	

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived at institution: Residence before admission) a. STATE <u>MISSOURI</u> COUNTY <u>JACKSON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Length of stay in 1b <u>25 YRS</u>	c. CITY OR TOWN <u>KANSAS CITY</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>General Hospital</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>2011-E-11</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Joellen</u> First <u>Loellen</u> Middle <u>Lott</u> Last			4. DATE OF DEATH Month <u>July</u> Day <u>23</u> Year <u>1962</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>NEGRO</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>3-11-1899</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	9. AGE (last birthday) <u>63</u> IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HR: Months _____ Days _____ Hours _____ Min. _____
11a. BIRTHPLACE (City and state or country) <u>HOPE, ARK.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>DONT KNOW</u>		14. MOTHER'S MAIDEN NAME <u>MILLIE PARKER</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>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>MINNIE MORRISON, VENICE, CAL.</u>		Address _____	
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>Cerebral vascular accident</u>			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 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>7-16-62</u> to <u>7-23-62</u> and last saw her alive on <u>7-23-62</u> Death occurred at <u>7:15 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE 		22b. ADDRESS <u>2400 Cherry</u>	
22c. DATE SIGNED <u>7-24-62</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>8-1-1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LINCOLN</u>	
23d. LOCATION (City, town, or county) <u>KANSAS CITY, MO.</u>		(State)	
24. FUNERAL DIRECTOR <u>BROWN-HUDSON, K.P., MO</u>		25. DATE RECD. BY LOCAL REG. <u>7-30-62</u>	26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>

STATE OF MISSISSIPPI
DEPARTMENT OF HEALTH

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. _____

P. O. Address _____

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.