

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
DEPARTMENT OF PUBLIC HEALTH AND WELFARE

3791-62-027300
STATE FILE NUMBER

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

DO NOT WRITE ON THIS STUB AMENDED

VS 300
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 Frank Ellis

FILED AUG 2 1962

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 lb 50 YEARS

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION General Hospital Inside Limits Yes No

d. STREET ADDRESS (If outside, give location) 3301 CHARLOTTE Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last Charles Pope

4. DATE OF DEATH Month Day Year July 18, 1962

5. SEX Male 6. COLOR OR RACE White 7. Married Never Married Widowed Divorced

8. DATE OF BIRTH 7-16-1919 9. AGE (last birthday) 83 YEARS

IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HR

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED PAINTER 10b. KIND OF BUSINESS OR INDUSTRY HOUSE WINTER 11. BIRTHPLACE (City and state or country) CAMBRIDGE MO. 12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME JOSEPH POPE 13b. MOTHER'S MAIDEN NAME UNKNOWN 14. NAME OF HUSBAND OR WIFE ALICE POPE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO 17. INFORMANT CHARLES O. POPE 2834 GARFIELD 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) Broncho-pneumonia
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. Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 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 NOT WHILE AT WORK 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 7-5-62 to 7-18-62 and last saw her/him alive on 7-18-62
Death occurred at 7:40 P on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) [Signature] 22b. ADDRESS 2400 Cherry 22c. DATE SIGNED 7-19-62

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE 7-21-62 23c. NAME OF CEMETERY OR CREMATORY MEMORIAL PARK 23d. LOCATION (City, town, or county) (State) KANSAS CITY, MO.

24. FUNERAL DIRECTOR MUEHLERBACK 68 1/2 ROOST ADDRESS 25. DATE RECD. BY LOCAL REG. 7-20-62 26. REGISTRAR'S SIGNATURE Ruth H 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 *A. L. Nichols*

Licensed Embalmer No. 7987

P. O. Address 15. C. 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.