

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

3596-62-027401
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1022 Registrar's No.

FILED III 25 1962

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

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. MISSOURI COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) KANSAS CITY		Length of stay in lb 2 mos	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4138 MICHIGAN		d. STREET ADDRESS (If outside, give location) 4138 MICHIGAN	
3. NAME OF DECEASED (Type or print) First Middle Last GLORIA WILLIAM		4. DATE OF DEATH Month Day Year 7-5-1962	
5. SEX FE	6. COLOR OR RACE COL	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4-8-1962
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) CHICAGO, ILL. U.S.A
13a. FATHER'S NAME THOMAS WILLIAM		13b. MOTHER'S MAIDEN NAME MAUDE WALKER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, go on or unknown) (If yes, give war or dates of service) N/A		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT THOMAS WILLIAM, K.C., Mo		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) malnutrition			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 s.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 _____, to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE L. M. [Signature] Deputy Coroner		22b. ADDRESS 1618 Lydia Ave.	22c. DATE SIGNED 7/6/62
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 7-10-62	23c. NAME OF CEMETERY OR CREMATORY LINCOLN	23d. LOCATION (City, town, or county) KANSAS CITY, Mo.
24. FUNERAL DIRECTOR BROWN-HUDSON, K.C., Mo.		25. DATE RECD. BY LOCAL REG. 7-9-62	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 _____

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.