

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-030847

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4321

FILED SEP 10 1962

1. PLACE OF DEATH a. COUNTY <u>Jackson</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u> Length of stay in lb <u>32yrs.</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Wheatley Hospital</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u> c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>2322 Brooklyn</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>Savannah</u> Middle <u>Bell</u> Last <u>Bell</u>		4. DATE OF DEATH Month <u>8</u> Day <u>21</u> Year <u>62</u>									
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8-14-84</u>	9. AGE (last birthday) <u>78</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>					
10a. USUAL OCCUPATION (Give kind of work done, during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (City and state or country) <u>Woodson Arkansas</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>					
13a. FATHER'S NAME <u>Unknown</u>			13b. MOTHER'S MAIDEN NAME <u>Francis Searcy</u>		14. NAME OF HUSBAND OR WIFE <u>None Charlie</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>None</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Pleasanna Franklin 2322 Brooklyn</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>Anoxia</u> DUE TO (b) <u>Cerebral vascular accident</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH					
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 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 <u> </u> a.m. <u> </u> p.m. Month, Day, Year <u> </u>		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>8-1-62</u> , to <u>8-21-62</u> and last saw her alive on <u>8-21-62</u> Death occurred at <u>5:00 p.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.						22a. SIGNATURE (Degree or title) <u>V. C. Dixon, M.D.</u>		22b. ADDRESS <u>2204 1/2 East 18th St. Kansas City 27, Mo.</u>		22c. DATE SIGNED <u>8-22-62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>8-25-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Highland</u>		23d. LOCATION (City, town, or county) (State) <u>Kansas City Mo.</u>						
24. FUNERAL DIRECTOR ADDRESS <u>Jones & Stevens 2315 Linwood</u>			25. DATE RECD. BY LOCAL REG. <u>8-22-62</u>		26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>						

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 ITEM NO. SHOULD READ
 INSTEAD OF
 DOCUMENT
 BY AFFIDAVIT OF
 MEDICAL CERTIFICATION
 V. C. DIXON

VS 300 Rev. 4/59
 1
 2 7000
 3
 4 3
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 9 9331X
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 12 70-0
 13

USE BLACK INK OR TYPEWRITER RIBBON

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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 Lauren Jones

Licensed Embalmer No. 4420

P. O. Address 231 [unclear]

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.