

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-031069

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4115

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

USE BLACK INK OR TYPEWRITER RIBBON

BY AFFIDAVIT OF

DOCUMENT

MEDICAL CERTIFICATION

M. Hillman

Deputy Coroner

FILED AUG 28 1962							
<p>1. PLACE OF DEATH</p> <p>a. COUNTY Jackson</p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City Length of stay in 1b 5 yrs.</p> <p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2905 Forest Avenue Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE Missouri b. COUNTY Jackson</p> <p>c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) 1806 1/2 Forest Avenue Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>						
<p>3. NAME OF DECEASED First Middle Last Doris Humphress 4. DATE OF DEATH Month Day Year August 4, 1962</p>							
<p>5. SEX Female</p>	<p>6. COLOR OR RACE Col.</p>	<p>7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/></p>	<p>8. DATE OF BIRTH 8/3/27</p>	<p>9. AGE (last birthday) 35</p>	<p>IF UNDER 1 YEAR Months Days</p> <p>IF UNDER 24 HR Hours Min.</p>		
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress</p>		<p>10b. KIND OF BUSINESS OR INDUSTRY Restaurant</p>		<p>11. BIRTHPLACE (City and state or country) Oklahoma</p>		<p>12. CITIZEN OF WHAT COUNTRY U.S.</p>	
<p>13a. FATHER'S NAME Elijah Tatum</p>			<p>13b. MOTHER'S MAIDEN NAME Hazel Doyle</p>			<p>14. NAME OF HUSBAND OR WIFE None</p>	
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No</p>		<p>16. SOCIAL SECURITY NO. None</p>		<p>17. INFORMANT Address Mrs. Hazel Wells, Mangum, Okla.</p>			
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:</p> <p style="text-align: center;">IMMEDIATE CAUSE (a) Subdural Hematoma (Evacuated) Healed.</p> <p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Paraplegia</p> <p>DUE TO (c) Assault & Battery</p>							
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Craniotomy - Sacral Decubitus</p>					<p>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</p>		
<p>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>		<p>20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/></p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) Don't know</p>			
<p>20c. TIME OF INJURY Hour a.m. p.m. 12/11/61</p>		<p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/></p>		<p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 1806 Forest Ave</p>		<p>20f. CITY, TOWN, OR LOCATION COUNTY STATE Kansas City, Jackson, Mo</p>	
<p>21. I attended the deceased from _____ to _____ and last saw him/her live on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.</p>							
<p>22a. SIGNATURE (Degree or title) Deputy Coroner</p>				<p>22b. ADDRESS 1618 Lydia Ave.</p>		<p>22c. DATE SIGNED 8/8/62</p>	
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) Removal-Ant.</p>		<p>23b. DATE 8/9/62</p>	<p>23c. NAME OF CEMETERY OR CREMATORY University of K.C.</p>		<p>23d. LOCATION (City, town, or county) (State) Kansas City, Jackson, Mo.</p>		
<p>24. FUNERAL DIRECTOR ADDRESS Badeau, Appleton & Jones, K.C., Mo.</p>			<p>25. DATE RECD. BY LOCAL REG. 8-9-62</p>		<p>26. REGISTRAR'S SIGNATURE Ruth Long</p>		

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 John R. Sidman
Licensed Embalmer No. 4531
P. O. Address Kansas City, 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.