

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

62-034105
STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 71 Primary Registration District No. 3012 Registrar's No. 102

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

16001

26001

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1296-0

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | |
|---|---|
| FILED SEP 24 1962 | |
| 1. PLACE OF DEATH | |
| a. COUNTY Clay | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Excelsior Springs | a. STATE Missouri b. COUNTY Clay |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 551 Orchard Place | c. CITY OR TOWN Excelsior Springs |
| d. STREET ADDRESS 551 Orchard Place | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) | |
| First Toleda | Middle E. |
| Last Frank | 4. DATE OF DEATH Sept. 5, 1962 |
| 5. SEX Female | 6. COLOR OR RACE White |
| 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 12-28-1899 |
| 9. AGE (last birthday) 62 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home |
| 11. BIRTHPLACE (City and state or country) Ray County, Mo. | 12. CITIZEN OF WHAT COUNTRY USA |
| 13a. FATHER'S NAME Joseph Camden | 13b. MOTHER'S MAIDEN NAME Jane Minnick |
| 14. NAME OF HUSBAND OR WIFE Roy Frank | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No |
| 16. SOCIAL SECURITY NO. Unknown | 17. INFORMANT Dorothy Jackson, 551 Orchard Place, Excelsior Springs, Mo. |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | |
| PART I. DEATH WAS CAUSED BY: | |
| IMMEDIATE CAUSE (a) Cardiac Stenosis | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) Severe myocardial infarction |
| | DUE TO (c) Primum myocardial infarction |
| 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 checked="" 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>Aug 20, 1962</u> to <u>Sept 5, 1962</u> and last saw her ^{alive} on <u>9/5/62</u> Death occurred at <u>2:00 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated. | |
| 22a. SIGNATURE <i>James R. Allen, M.D.</i> | 22b. ADDRESS 110 E. BROADWAY, EXCEL. SPGS., MO. |
| 22c. DATE SIGNED 9-6-62 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 9-7-62 |
| 23c. NAME OF CEMETERY OR CREMATORY Union Cemetery | |
| 23d. LOCATION (City, town, or county) (State) Rural, Orrick, Mo. | |
| 24. FUNERAL DIRECTOR Prichard Funeral Home, Inc. | 25. DATE RECD. BY LOCAL REG. 9-6-62 |
| 26. REGISTRAR'S SIGNATURE <i>Caroline Hutchings</i> | |

USE BLACK INK OR TYPEWRITER RIBBON

Business Permit Renewed 9-6-62 - E. H. H.

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 Lindie Jarman

Licensed Embalmer No. 4589

P. O. Address Excelsior Springs, 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.