

T. MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

62-034133
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 393 Primary Registration District No. 1002 Registrar's No. 4912

FILED OCT 8 1962

VS 300 Rev. 4/59
16008
26004
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4 1
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

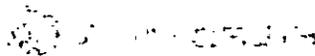
MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Clay</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u> Length of stay in lb <u>2 Mths.</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>523 1/2 Minger Rd. Guardian Angel Home</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clay</u> c. CITY OR TOWN <u>North Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>2016 Fayette</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Alberta</u> Middle <u>(None)</u> Last <u>Winbigler</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>23</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9-26-73</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Apartment Bldg.</u>	11. BIRTHPLACE (City and state or country) <u>Excelsior Springs, Mo. U.S.A.</u>
13a. FATHER'S NAME <u>John Wright</u>		13b. MOTHER'S MAIDEN NAME <u>Fannie Turner</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>		17. INFORMANT Address <u>N.K. C. Mo. Roy D. Winbigler 338 East 26th Ave.</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>Pulmonary Edema</u> DUE TO (b) <u>Congestive Heart Failure</u> DUE TO (c) <u>Coronary Arteriosclerosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>Weeks</u> <u>11</u> <u>several years</u>
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> 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>April 1962</u> to <u>Sept 1962</u> and last saw her/him alive on <u>Sept 18-62</u> . Death occurred at <u> </u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Paul Revare MD.</u> (Degree or title)		22b. ADDRESS <u>North Kansas City, Mo</u>	
22c. DATE SIGNED <u>9-24-62</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9-25-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Crown Hill Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Excelsior Springs, Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>D. W. Newcomers Sons North Kansas City, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>9-25-62</u>	26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>

USE BLACK INK OR TYPEWRITER RIBBON

Dr. Reese



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 *Marvin D. Preston*

Licensed Embalmer No. *50440*

P. O. Address *No. K. C. 740*

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.