

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-034804

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4575 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED SEP 28 1962

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Rev. 4/59

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DATE AMENDED

10/16/62

10/16/62

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

acute circulatory failure

Cause undetermined

Pending Lab. Exam.

DOCUMENT

BY AFFIDAVIT OF attending physician

D. C. Kealhof M.D. MEDICAL CERTIFICATION

USE BLACK INK OR TYPEWRITER RIBBON

| | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH- a. COUNTY Jackson | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Jackson | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City | | Length of stay in lb 13 Yrs | c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 639 E. 73rd Terrace | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 639 E. 73rd Terrace Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Ann Middle Mildred Last Howard | | | 4. DATE OF DEATH Month September Day 4 Year 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 5-30-1908 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary | | 10b. KIND OF BUSINESS OR INDUSTRY Realty Hardin-Stockton | 9. AGE (last birthday) 54 Yrs IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min. |
| 11. BIRTHPLACE (City and state or country) Plattsburg, Missouri | | 12. CITIZEN OF WHAT COUNTRY USA | |
| 13a. FATHER'S NAME M. O. Richardson | | 13b. MOTHER'S MAIDEN NAME Ella German | |
| 14. NAME OF HUSBAND OR WIFE Byron J. Howard | | 17. INFORMANT Robert Howard 639 E. 73rd Terrace | |
| 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. [REDACTED] | |
| 18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute circulatory failure DUE TO (b) (Cause undetermined) DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | |
| 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 checked="" 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 _____ Month, Day, Year _____ a.m. _____ p.m. _____ | | | |
| 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. | | | |
| 22. SIGNATURE (Degree or title) [Signature] | | 22b. ADDRESS 6621 Pleasant St. Overland Park, Mo. | |
| 22c. DATE SIGNED 9-6-62 | | (State) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 9-7-62 | 23c. NAME OF CEMETERY OR CREMATORY Calvary | 23d. LOCATION (City, town, or county) Kansas City, Missouri |
| 24. FUNERAL DIRECTOR Stine & McClure Kansas City, Missouri | | 25. DATE RECD. BY LOCAL REG. 9-6-62 | 26. REGISTRAR'S SIGNATURE [Signature] |

9.20.62

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 William M. Turner

Licensed Embalmer No. 4648

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.

MEDICINE CERTIFICATION