

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-034999

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4885 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED OCT 8 1962

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY JACKSON | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY | | c. CITY OR TOWN KANSAS CITY | |
| Length of stay in lb 16 YRS | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 531 MARSH | | d. STREET ADDRESS (If outside, give location) 531 MARSH | |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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|---|--|--|---|--|--|--|
| 3. NAME OF DECEASED (Type or print) ZULLA MAE SOULDER | | | 4. DATE OF DEATH Month 9 Day 21 Year 62 | | | |
|---|--|--|---|--|--|--|

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|-------------------------|----------------------------------|---|--------------------------------------|-------------------------------------|---------------------------|------------------------|-------|------|
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 5-17-1915 | 9. AGE (last birthday) 47 | IF UNDER 1 YEAR Months | IF UNDER 24 HR Days | Hours | Min. |
|-------------------------|----------------------------------|---|--------------------------------------|-------------------------------------|---------------------------|------------------------|-------|------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) SENTINAL MO. | 12. CITIZEN OF WHAT COUNTRY U. S. A. |
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| | | |
|--|---|---|
| 13a. FATHER'S NAME WILLIAM ADAMS | 13b. MOTHER'S MAIDEN NAME MELUINA HICKS | 14. NAME OF HUSBAND OR WIFE WILLARD SOULDER |
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| 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. NONE | 17. INFORMANT WILLARD SOULDER 531 MARSH K. C. MO |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) Coronary Occlusion | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) | |
| | DUE TO (c) | |

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| 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 | |
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| 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.) |
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| 20c. TIME OF INJURY Hour 1 a.m. p.m. | Month, Day, Year |
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|--|--|------------------------------|--------|-------|
| 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.

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| 22a. SIGNATURE <i>Hugh A. Owens</i> | (Degree or title) | 22b. ADDRESS 152 Union Station | 22c. DATE SIGNED 9-22-62 |
|--|-------------------|--|------------------------------------|

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|---|-----------------------------|--|--|
| 23a. BIRTH, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE 9-24-62 | 23c. NAME OF CEMETERY OR CREMATORY MEMORIAL PARK | 23d. LOCATION (City, town, or county) KANSAS CITY MO |
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| 24. FUNERAL DIRECTOR SHELL FUNERAL HOME K. C. MO. | ADDRESS | 25. DATE RECD. BY LOCAL REG. 9-24-62 | 26. REGISTRAR'S SIGNATURE <i>Ruth Long</i> |
|---|---------|--|---|

USE BLACK INK OR TYPEWRITER RIBBON

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 Thomas A. Shiel

Licensed Embalmer No. 4954

P. O. Address K.C.M.

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.