

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

5033-62-038678
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

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

FILED OCT 19 1962

VS 300
Rev. 4/59

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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 JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE KANSAS b. COUNTY Crawford	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Length of stay in 1b 21 days	c. CITY OR TOWN GIRARD
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VA HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 408 W. 3rd
3. NAME OF DECEASED (Type or print) First WILHELM Middle H. Last DUMOLT		4. DATE OF DEATH Month OCTOBER Day 3 Year 1962	
5. SEX MALE	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 3-13-97
9. AGE (last birthday) 65		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (City and state or country) Billingsville, Mo. USA
12. CITIZEN OF WHAT COUNTRY USA		13. FATHER'S NAME Joseph Dumolt	
14. MOTHER'S MAIDEN NAME Elizabeth Reine		15. NAME OF HUSBAND OR WIFE Florence Dumolt	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWI		17. SOCIAL SECURITY NO. _____	
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA		INTERVAL BETWEEN ONSET AND DEATH 3 days	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) CEREBRAL ATROPHY		8 1/2 years	
DUE TO (c) _____			
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 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. Attended the deceased from 9-12-62 to 10-3-62		Death occurred at 3:30 p. m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <i>Dale S. Griswold</i> (Degree or title) M.D.		22b. ADDRESS VA Hospital, K. C. Mo.	22c. DATE SIGNED 10-3-62
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 10-5-1962	23c. NAME OF CEMETERY OR CREMATORY Natio nal Cemetery	23d. LOCATION (City, town, or county) (State) Ft. Leavenworth, Kansas
24. FUNERAL DIRECTOR Eugene P. Amos		25. DATE RECD. BY LOCAL REG. 10-4-62	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 _____
Eugene P. Amos
Licensed Embalmer No. 5 023

P. O. Address Sh. awnee, Kansas

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.