

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-038785

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5120

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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2 3858
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4 0
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

Carl R. Ferris

FILED OCT 19 1962		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		Length of stay in lb Lifetime		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 Research Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 437 West Dartmouth Road Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Martin Last Keith			4. DATE OF DEATH Month October Day 6 Year 1962		
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8/6/04	9. AGE (last birthday) 58 Years IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HR: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Vice-President - Electronics Sales, Inc.		10b. KIND OF BUSINESS OR INDUSTRY Automatic General		11. BIRTHPLACE (City and state or country) Kansas City, Mo. USA	
13a. FATHER'S NAME Peter Keith		13b. MOTHER'S MAIDEN NAME Margaret Bates		14. NAME OF HUSBAND OR WIFE Mrs. Janette Keith	
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. _____		17. INFORMANT 437 W. Dartmouth Road, Mrs. Janette Keith, Kansas City, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for part I, part II, or part III) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH 24 Hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not listed in the technical cause of death. If deceased was female was there a pregnancy in last 90 days. Arterio-sclerosis, Anticoagulant drug abuse, Cirrhosis of the Liver - over 4 years duration					
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 June 7, 1958 to Oct 6 1962 and last saw him alive on Oct 6, 1962 Death occurred at 10:00 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE Carl R. Ferris M.D.		22b. ADDRESS 6400 Prospect Ave. Kansas City, Mo.		22c. DATE SIGNED 10-8-62	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE Oct. 9, 1962		23c. NAME OF CEMETERY OR CREMATORY Bellefontaine Avenue St. Louis Missouri	
24. FUNERAL DIRECTOR D. W. NEWCOMER'S SONS 1331 Brush Creek Blvd.		25. DATE RECD. BY LOCAL REG. 10-9-62		26. REGISTRAR'S SIGNATURE Ruth Long	

USE BLACK INK OR TYPEWRITER RIBBON

Dr. Carl Ray Jones
Suite # 316, Boardwalk Office Building - 6400 Prospect
12:00 - 4:00

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 Lenib. Michael

Licensed Embalmer No. 4340

P. O. Address S. C., 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.