

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-038827

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5436 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED NOV 9 1962

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF Robert H. Hodge

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Texas</u> b. COUNTY <u>Dallas</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kansas City</u>		Length of stay in lb <u>21 da</u>	c. CITY OR TOWN <u>Garland</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) <u>Trinity Lutheran</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1014 Lourock dr.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Alsey</u> Middle <u>Berry</u> Last <u>Lott</u>			4. DATE OF DEATH Month <u>Oct.</u> Day <u>25</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>4-8-94</u>	9. AGE (last birthday) <u>68</u>	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) <u>at home</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>house work</u>	11. BIRTHPLACE (City and state or country) <u>Yellowville, Ark</u>	12. CITIZEN OF WHAT COUNTRY <u>US.</u>
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13. FATHER'S NAME <u>James C Berry</u>	13b. MOTHER'S MAIDEN NAME <u>Edna Layton</u>	14. NAME OF HUSBAND OR WIFE <u>Thomas Lott</u> <u>Deceased 1960</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>no</u>	17. INFORMANT <u>Jessie C Emond</u> Address <u>900 Main Parkville Mo</u>
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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: IMMEDIATE CAUSE (a) <u>Cor Pulmonale</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1-2 yrs.</u>
DUE TO (b) <u>Emphysema</u>		
DUE TO (c) <u>Lymphosarcoma</u>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Pulmonary Emphysema & Bronchial Catarrh</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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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.)
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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 _____
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21. I attended the deceased from <u>9-19-62</u> to <u>10-25-62</u> and last saw her <u>her</u> alive on <u>10-25-62</u> Death occurred at <u>6:45 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Robert H Hodge md</u> (Degree or title)	22b. ADDRESS <u>North Kansas City, Mo</u>	22c. DATE SIGNED <u>10-26-62</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Oct 26-62</u>	23b. DATE <u>Oct 26-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Galaxy Hill</u>	23d. LOCATION (City, town, or county) (State) <u>Dallas Texas</u>
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24. FUNERAL DIRECTOR <u>Lehud N Francis</u> ADDRESS <u>Parkville Mo</u>	25. DATE RECD. BY LOCAL REG. <u>10-26-62</u>	26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>
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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 Leland H. Francis

Licensed Embalmer No. 3451

P. O. Address Parkville, 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.

Dr Robert Hoelge. 329 Ammon - N/K. B41-3229.