

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-038851

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5407

FILED NOV 1 1962

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>JACKSON</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MISSOURI</b> b. COUNTY <b>CLAY</b> |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>KANSAS CITY</b>                   |  | Length of stay in 1b<br><b>12 Years</b>   | c. CITY OR TOWN <b>KANSAS CITY NORTH</b><br>Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>VA HOSPITAL, KC, MO</b> |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location)<br><b>1801 E. 54th Terr</b><br>Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print)<br>First <b>DONALD</b> Middle <b>FLOYD</b> Last <b>MILLER</b> |  |  | 4. DATE OF DEATH<br>Month <b>OCTOBER</b> Day <b>22</b> Year <b>1962</b> |  |  |
|---|--|--|---|--|--|

|                       |                                  |   |                                     |                                     |  |  |
|-----------------------|----------------------------------|---|-------------------------------------|-------------------------------------|--|--|
| 5. SEX<br><b>MALE</b> | 6. COLOR OR RACE<br><b>WHITE</b> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>12-19-19</b> | 9. AGE (last birthday)<br><b>42</b> | IF UNDER 1 YEAR<br>Months _____ Days _____ | IF UNDER 24 HR<br>Hours _____ Min. _____ |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>TRUCK DRIVER</b> | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country)<br><b>MARTIN CITY, MO.</b> | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b> |
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| 13a. FATHER'S NAME<br><b>FRED MILLER</b> | 13b. MOTHER'S MAIDEN NAME<br><b>ZOLA HOFFMAN</b> | 14. NAME OF HUSBAND OR WIFE<br><b>MARGARET</b> |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>YES WW II</b> | 17. INFORMANT<br>Address<br><b>Official Records VA Hospital, K.C., Mo.</b> |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:                          |   | INTERVAL BETWEEN ONSET AND DEATH   |
| IMMEDIATE CAUSE (a) <b>Multiple pulmonary infarction</b>  |   |  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.  | DUE TO (b) <b>Healed myocardial infarction with mural thrombosis, extensive</b> |  |
| DUE TO (c) <b>Coronary atherosclerosis.</b>   |   |  |
| 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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |

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| 19. WAS AUTOPSY PERFORMED?<br>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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|   |                  |
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| 20c. TIME OF INJURY<br>Hour _____ 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<br>COUNTY _____ STATE _____ |
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| 21. <b>VA</b> attended the deceased from <b>10-19-62</b> to <b>10-22-62</b><br>Death occurred at <b>4:05 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated. |
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| 22a. SIGNATURE (Name or title)<br><b>Virgilio Sanganang, M.D.</b> | 22b. ADDRESS<br><b>VA Hospital, Kansas City, Mo.</b> | 22c. DATE SIGNED<br><b>10-23-62</b> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>REMOVAL</b> | 23b. DATE<br><b>10-25-1962</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>NATIONAL Cem.</b> | 23d. LOCATION (City, town, or county) (State)<br><b>FT. LEAVENWORTH, KANS.</b> |
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| 24. FUNERAL DIRECTOR<br><b>D.W. Newcomer's Sons - KAN. CITY.</b> | 25. DATE RECD. BY LOCAL REG.<br><b>10-24-62</b> | 26. REGISTRAR'S SIGNATURE<br><b>Ruth Long</b> |
|--|---|---|

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

| ITEM NO. | SHOULD READ | DATE AMENDED   | INSTEAD OF | DOCUMENT |
|----------|-------------|----------------|------------|----------|
| 1        |             |                |            |          |
| 2        |             | <b>6/26/68</b> |            |          |
| 3        |             |                |            |          |
| 4        |             | <b>0</b>       |            |          |
| 5        |             | <b>1</b>       |            |          |
| 6        |             |                |            |          |
| 7        |             | <b>0</b>       |            |          |
| 8        |             | <b>1</b>       |            |          |
| 9        |             | <b>94201</b>   |            |          |
| 10       |             |                |            |          |
| 11       |             |                |            |          |
| 12       |             | <b>76-0</b>    |            |          |
| 13       |             |                |            |          |

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

**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

*Marvin D. Preston*

Licensed Embalmer No. 5040

P. O. Address No. K.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.