

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-042385

Registration District No. 137 Primary Registration District No. 3023 Registrar's No. 286

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

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DATE AMENDED

INSTEAD OF

SHOULD READ

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DOCUMENT

BY AFFIDAVIT OF

FILED NOV 26 1962		1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>Clinton General Hosp</u> <u>Henry County</u>		b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Clinton Mo.</u> Length of stay in 1b		a. STATE <u>MO</u>	b. COUNTY <u>CLAY</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Clinton General Hosp.</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Harrisonville Mo</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>RAY</u> Middle <u>Lee</u> Last <u>Wehmejer</u>		4. DATE OF DEATH Month <u>11</u> Day <u>23</u> Year <u>1962</u>		d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11-23-1962</u>	9. AGE (last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min. <u>18 1/2</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Clinton Mo</u>	
13a. FATHER'S NAME <u>Robert E. Wehmejer</u>		13b. MOTHER'S MAIDEN NAME <u>BURR</u>		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Robert Wehmejer</u> Address <u>Harrisonville Mo.</u>	
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 <u>18 hr.</u>
IMMEDIATE CAUSE (a) <u>Atelectasis</u>					
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					
DUE TO (b)					
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 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 <u>11-23-62</u> to <u>11-23-62</u> and last saw <sup>her</sup> <sub>(him)</sub> <u>live on 11-23-62</u>					
Death occurred at <u>10:20 p</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Hugh B. Walker, MD</u>			22b. ADDRESS <u>Clinton, Mo</u>		22c. DATE SIGNED <u>11-24-62</u>
23a. BURIAL, CREMATION, OR REMOVAL (Specify)	23b. DATE <u>Nov 25, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Graves City</u>		23d. LOCATION (City, town, or county) (State) <u>Graves City, Clay Mo</u>	
24. FUNERAL DIRECTOR <u>W. G. Brown</u> ADDRESS <u>Union Mo</u>			25. DATE RECD. BY LOCAL REG. <u>Nov. 24 1962</u>		26. REGISTRAR'S SIGNATURE <u>Mildred Bigum</u>

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

*A. R. Kenney*

Licensed Embalmer No.

*3099*

P. O. Address

*Clinton MD*

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.