

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-042692

6122

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

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

FILED DEC 14 1962

VS 300
Rev. 4/59

1

2 0830

3

4 0

5 1

6

7 1

8 1

9 332X

10

11

12 61-0

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. 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 Missouri b. COUNTY Platte	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 2 weeks	c. CITY OR TOWN Parkville
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Menorah Medical Center		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) RFD #4
3. NAME OF DECEASED (Type or print) First WILLIAM Middle M. Last HOLSTED		4. DATE OF DEATH Month December Day 2 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 3-3-1892
9. AGE (last birthday) 70		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) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (City and state or country) Paris, Arkansas
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME Albert C. Holsted	
13b. MOTHER'S MAIDEN NAME Martha E. Agee		14. NAME OF HUSBAND OR WIFE Lillie Holsted	
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. None	17. INFORMANT Lillie Holsted RFD#4 Parkville, Mo.
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerephalomalacia, lt. temporoparietal lobe 1 week DUE TO (b) Thrombosis, lt. middle cerebral artery 2 weeks DUE TO (c) Generalized arteriosclerosis 10+ years. Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). Diabetes mellitus		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 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.)	
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>Sept 6, 1962</u> to <u>Dec 2, 1962</u> and last saw him alive on <u>Dec 2, 1962</u> . Death occurred at _____ <u>1:00</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>A. E. Braverman</i> (Degree or title) MD		22b. ADDRESS 701 E. 63rd Kansas City 10, Mo.	22c. DATE SIGNED 12/4/62 (Site)
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE December 3, 1962	23c. NAME OF CEMETERY OR CREMATORY Horton Cemetery	23d. LOCATION (City, town, or county) Bosworth, Missouri
24. FUNERAL DIRECTOR Liepard-Edwards Bosworth, Missouri		25. DATE RECD. BY LOCAL REG. 12-4-62	26. REGISTRAR'S SIGNATURE <i>Ruth Song</i>

USE BLACK INK OR TYPEWRITER RIBBON

UNITED DELTA CHAPTER

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 Wayne Smith

Licensed Embalmer No. 5081

P. O. Address Indep. 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.