

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-042946

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 189 Primary Registration District No. 1002 Registrar's No. 5915

FILED DEC 10 1962

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <b>Jackson</b>		a. STATE <b>Mo.</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		c. CITY OR TOWN <b>Kansas City</b>	
Length of stay in 1b <b>70 yrs.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Brown Nursing Home</b>		d. STREET ADDRESS (If outside, give location) <b>1610 E. 22nd. Terr.</b>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH
First <b>Birdie</b> Middle <b>Baker</b> Last <b>Starnes</b>			Month <b>11</b> Day <b>19</b> Year <b>62</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>7-18-1882</b>
9. AGE (last birthday) <b>80 Yrs.</b>		IF UNDER 1 YEAR	IF UNDER 24 HR
		Months	Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maid</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Nelly Don</b>	11. BIRTHPLACE (City and state or country) <b>Alton, Ill.</b>
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13a. FATHER'S NAME <b>William Baker</b>	
13b. MOTHER'S MAIDEN NAME <b>Lydia Mozee</b>		14. NAME OF HUSBAND OR WIFE <b>James Starnes</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Gertrude Day</b>		Address <b>K. C. Mo. 1610 E. 22nd. St. Terr.</b>	
18. CAUSE OF DEATH (Enter only one cause per line if PART I. DEATH WAS CAUSED BY)			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE <b>Cerebral Thrombosis</b>			<b>4 days</b>
Generalized Arteriosclerosis			
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 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. Month, Day, Year		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 <b>15 Nov 62</b> to <b>19 Nov 62</b> and last saw her alive on <b>19 Nov 62</b>		Death occurred at <b>5307 P</b> m on the date stated above, and to the best of my knowledge, from the causes stated.	
22. SIGNATURE (Degree or title) <b>John H. Wells MD</b>		22b. ADDRESS <b>3718 Prospect</b>	22c. DATE SIGNED <b>11/23/62</b>
23. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>11-24-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Highland</b>	23d. LOCATION (City, town, or county) <b>Kansas City, Mo.</b>
24. FUNERAL DIRECTOR <b>Jones &amp; Stevens</b>	ADDRESS <b>2315 Linwood</b>	25. DATE RECD. BY LOCAL REG. <b>11-23-62</b>	26. REGISTRAR'S SIGNATURE <b>Ruth Long</b>

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 Lawrence A. Jones

Licensed Embalmer No. 10429  
P. O. Address 3311 Lenox Blvd  
Capitol Hill

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.