

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-042085  
STATE FILE NUMBER

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 548

DO NOT WRITE ON THIS STUB

AMENDED

**FILED NOV 16 1962**

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Independence</b>		Length of stay in 1b <b>2 weeks</b>	c. CITY OR TOWN <b>Sugar Creek</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>Independence San &amp; Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>110 So. Claremont</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Martin</b> Middle <b>Davis</b> Last <b>Onka</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>11</b> Year <b>1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>2-12-1961</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INFANT</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>INFANT</b>	9. AGE (last birthday) <b>1</b> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HR: Hours _____ Min. _____
11a. BIRTHPLACE (City and state or country) <b>INDEPENDENCE, MO.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>ROBERT L. ONKA</b>		13b. MOTHER'S MAIDEN NAME <b>JO ANN MARTIN</b>	
14. NAME OF HUSBAND OR WIFE <b>NONE</b>		17. INFORMANT <b>Robert L. Onka, 110 S. Claremont, Sugar Crk.</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>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage, gastrointestinal</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Acute Leukemia</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			INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>5 months</b>
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. _____ 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 <b>8-5-62</b> to <b>11-11-62</b> and last saw her/him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE (Degree or title) <b>Charles A. Kendall M.D.</b>		22b. ADDRESS <b>Independ. Mo.</b>	22c. DATE SIGNED <b>11-13-62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>11-13-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MT. OLIVET CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>KANSAS CITY, MO.</b>
24. FUNERAL DIRECTOR <b>Geo. C. Carson &amp; Sons Independence, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>11-13-62</b>	26. REGISTRAR'S SIGNATURE <b>Alba L. Craig</b>

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300  
Rev. 4/59

1 7005

2 7006

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9 204.3

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11

12 1-0

13 1-0

USE BLACK INK OR TYPEWRITER RIBBON

NOV 20 1962

DEC 27 1962

NOV 13-1962

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 Charles F. Tyler  
Licensed Embalmer No. 4534

P. O. Address Sherry NW

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.