

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-043712

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 200 Primary Registration District No. _____ Registrar's No. 80

FILLED NOV 30 1962	
1. PLACE OF DEATH a. COUNTY <u>Platte</u>	
2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Platte</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Parkville</u> Length of stay in lb <u>50 yrs</u>	
c. CITY OR TOWN <u>Parkville Mo</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>at home</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. STREET ADDRESS (If outside, give location) <u>5818 Bell Rd. N.W.</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>(None)</u> Last <u>Ducret</u>	
4. DATE OF DEATH <u>Nov. 15 - 1962</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>
7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11/12/1889</u>
9. AGE (last birthday) <u>73</u>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Mail Clerk</u>
11. BIRTHPLACE (City and state or country) <u>Kansas City Mo.</u>	12. CITIZEN OF WHAT COUNTRY _____
13a. FATHER'S NAME <u>Paul Ducret</u>	13b. MOTHER'S MAIDEN NAME <u>Josephene Unrow</u>
14. NAME OF HUSBAND OR WIFE _____	Address <u>RFD</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>no</u>
17. INFORMANT <u>Mrs. Dean Leavel</u>	Address <u>Parkville, Mo</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>5 m</u> <u>10 years</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	
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. _____ 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>Jan 8, 196</u> , to <u>Nov 15 - 62</u> and last saw him alive on <u>Nov 1, 62</u> Death occurred at <u>9 a</u> m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <u>Neil Shuman</u> (Degree or title) _____	22b. ADDRESS <u>1600 Tower Parkville, Mo</u>
22c. DATE SIGNED <u>11-17-62</u>	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Nov 17 - 62</u>
23c. NAME OF CEMETERY OR CREMATORY <u>Walnut Grove</u>	23d. LOCATION (City, town, or county) (State) <u>Parkville Mo</u>
24. FUNERAL DIRECTOR <u>Leland H. Francis</u> ADDRESS <u>Parkville</u>	25. DATE RECD. BY LOCAL REG. <u>Nov. 17, 1962</u>
26. REGISTRAR'S SIGNATURE <u>Aphie Rollins</u>	

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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

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

NOV 30 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 *Leland H. Francis*

Licensed Embalmer No. 3451

P. O. Address Parkville, 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.