

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-047218

STATE FILE NUMBER

DO NOT WRITE ON THIS SUB

AMENDMENTS FILED

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 6477

JAN 7 1963

VS 300  
Rev. 4/59

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DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF  
WILSON H. MILLER

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) 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>		Length of stay in 1b <b>35 YEARS</b>	c. CITY OR TOWN <b>KANSAS CITY</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Research Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>527 BALES</b>
3. NAME OF DECEASED (Type or print) First <b>MILDRED</b> Middle <b>STAATS</b> Last <b>STAATS</b>		4. DATE OF DEATH Month <b>December</b> Day <b>18</b> Year <b>1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>2-16-905</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Homemaker</b>	11. BIRTHPLACE (City and state or country) <b>NEBRASKA</b>
13a. FATHER'S NAME <b>C. A. Duey</b>		14. NAME OF HUSBAND OR WIFE <b>ARLOE STAATS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		17. INFORMANT <b>MR ARLOE STAATS</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>Acute myocardial infarction</b>		INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Postoperative - Cholecystectomy</b>		<b>24 hrs</b>	
DUE TO (c) <b>Chronic cholelithiasis</b>		<b>unknown</b>	
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 checked="" 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 <input type="checkbox"/> s.m. <input type="checkbox"/> p.m. <input type="checkbox"/>	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>3/22/62</u> to <u>12/18/62</u> and last saw her <sup>him</sup> alive on <u>12/12/62</u> Death occurred at <u>9:40</u> <u>9</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Wilson H. Miller M.D.</b>		22b. ADDRESS <b>3626 Indep. Ave Kansas City 24, Mo.</b>	22c. DATE SIGNED <b>12/18/62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>12-20-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>GREENLAWN</b>	23d. LOCATION (City, town, or county) (State) <b>KANSAS CITY, MO.</b>
24. FUNERAL DIRECTOR <b>Muehlebach</b>		25. DATE RECD. BY LOCAL REG. <b>12-19-62</b>	26. REGISTRAR'S SIGNATURE <b>Ruth Long</b>

USE BLACK INK

OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

Dr. Wilson Miller  
3626 Indep. Ave.  
BE-1-2800  
(12<sup>30</sup> to 6:00 AM - Wed.)

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 Robert J. Landes

Licensed Embalmer No. 5103

P. O. Address K.C., 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.