

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-000737

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 72 Primary Registration District No. 3013 Registrar's No. 29

STATE FILE NUMBER

VS 300  
Rev. 4/59

1 6004  
2 10004  
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>Clay</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>North Kansas City</b>		Length of stay in 1b <b>4 days</b>	c. CITY OR TOWN <b>Jackson County</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>North Kansas City Memorial Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) <b>Blue Mills &amp; Sibley Rd.</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>MRS. OLIVE N.M.I. CHILES</b>			4. DATE OF DEATH Month <b>February</b> Day <b>7</b> Year <b>1963</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>Mar. 1, 1887</b>
9. AGE (last birthday) <b>75</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bates Co., Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
11. BIRTHPLACE (City and state or country)		13. FATHER'S NAME <b>Charles E. Harrold</b>	
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME <b>Emma Cairns</b>	
14. NAME OF HUSBAND OR WIFE <b>Mr. P. C. Chiles</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. P. C. Chiles</b> Address <b>Blue Mills &amp; Sibley Rd. Indep., Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerosis, Generalized</b> DUE TO (c) <b>Indef.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH. <b>48 hr</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		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	
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 <b>Sept 1960</b> to <b>Feb 7 1963</b> and last saw her <sup>her</sup> <sub>him</sub> alive on <b>2/7/63</b> Death occurred at <b>8:30 pm</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Clara W. Sanderson M.D.</i>		22b. ADDRESS <i>Liberty, Mo.</i>	
22c. DATE SIGNED <b>2/8/63</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
23b. DATE <b>February 9, 1963</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Buckner Cemetery</b>	
23d. LOCATION (City, town, or county) <b>Buckner, Missouri</b>		24. FUNERAL DIRECTOR <b>OTT &amp; MITCHELL, Indep., Mo.</b>	
25. DATE RECD. BY LOCAL REG. <b>2-8-63</b>		26. REGISTRAR'S SIGNATURE <i>Marguerite Judgers</i>	

(Licensed Embalmer's Statement on Reverse Side)

**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

*Henry H. Mitchell*

Licensed Embalmer No. 3925

P. O. Address Andover, 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.