

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-001558

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 609

STATE FILE NUMBER

63-001558

**FILED FEB 8 1963**

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Rev. 4/59

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DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF George K. Boyd

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kansas City</u>		Length of stay in 1b <u>5 Days</u>	c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) <u>St Joseph Hosp.</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1016 Locust</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>PHILLIP</u> Middle <u>L</u> Last <u>EWELL</u>		4. DATE OF DEATH Month <u>1</u> Day <u>23</u> Year <u>63</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6-3-88</u>
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>pipe lines</u>	11. BIRTHPLACE (City and state or country) <u>Tusculum Mo.</u>
13. FATHER'S NAME <u>Silas Ewell</u>		14. NAME OF HUSBAND OR WIFE <u>U.S.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>[REDACTED]</u>	
18. CAUSE OF DEATH (Enter only one cause per 1b) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO (b) <u>Cerebral Ischemia</u> DUE TO (c) <u>Cerebrovascular Insufficiency</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition listed in PART I (a) <u>Myocardial Hypertrophy</u> <u>Left Lower pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> <u>3 days</u> <u>2 years</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20c. TIME OF INJURY Hour <u>[REDACTED]</u> a.m. <u>[REDACTED]</u> p.m. <u>[REDACTED]</u> Month, Day, Year.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
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 <u>Jan 16, 1963</u> to <u>Jan 23, 63</u> and last saw him alive on <u>Jan 22, 1963</u> Death occurred at <u>6:05 Am</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>George K Boyd MD</u>		22b. ADDRESS <u>5111 Independence Ave</u>	
22c. DATE SIGNED <u>1-23-63</u>			
23. BURIAL, CREMATION, REMOVAL, (Specify) <u>Removal</u>		23b. DATE <u>1-23-63</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Candler</u>		23d. LOCATION (City, town, or county) (State) <u>Candler Mo</u>	
24. FUNERAL DIRECTOR <u>Reppert</u>		25. DATE RECD. BY LOCAL REG. <u>1-23-63</u>	
ADDRESS <u>Bushner Mo</u>		26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>	

USE BLACK INK OR TYPEWRITER RIBBON

FEB 8 1963

AUG 22 1963

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 E. Mayfield

Licensed Embalmer No. 4638

P. O. Address Blue Springs, 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.