

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-001583

STATE FILE NUMBER 267

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

DO NOT WRITE ON THIS STUB

AMENDED

FILED JAN 28 1963

VS 300
Rev. 4/59

1

20975

3

4 2

5 1

6

7 0

8 1

9212X

10

11

12 76-0

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI COUNTY SALINE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Length of stay in 1b 68 days	c. CITY OR TOWN MARSHALL Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION V A HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 372 WEST MARION Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE R GAINES			4. DATE OF DEATH Month Day Year January 15, 1963
5. SEX Male	6. COLOR OR RACE Negro	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1-27-08
9. AGE (last birthday) 54		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) Furniture company work		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Marshall, Missouri
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME George Gaines	
13b. MOTHER'S MAIDEN NAME Mary Brown		14. NAME OF HUSBAND OR WIFE Anna Gaines	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO. -	
17. INFORMANT Anna Gaines, wife		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute and chronic bronchopneumonitis of right lung, severe DUE TO (b) Possible mesothelioma of the right lung 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	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 Month, Day, Year a.m. p.m.			
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
I, MA attended the deceased from Nov. 8, 1962 to Jan. 15, 1963 Monday, 1963 Death occurred at 3:15 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Jun Soja JUN SOGA, M.D.		22b. ADDRESS VA Hospital, Kansas City, Mo.	22c. DATE SIGNED 1-16-63 (State)
23a. BURIAL, CREMATION, or other disposal (Specify) Burial	23b. DATE 1-16-63	23c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery	23d. LOCATION (City, town, or county) Marshall, Mo.
24. FUNERAL DIRECTOR George H. Shaw Fulton, Mo.		25. DATE RECD. BY LOCAL REG. 1-16-63	26. REGISTRAR'S SIGNATURE Ruth Song

USE BLACK INK OR TYPEWRITER RIBBON

JAN 28 1963

STATE OF MICHIGAN

DEPT. OF HEALTH

DEPT. OF HEALTH

STATE OF MICHIGAN

DEPT. OF HEALTH

DEPT. OF HEALTH

DEPT. OF HEALTH

DEPT. OF HEALTH

DEPT. OF HEALTH

DEPT. OF HEALTH

DEPT. OF HEALTH

DEPT. OF HEALTH

DEPT. OF HEALTH

DEPT. OF HEALTH

DEPT. OF HEALTH

DEPT. OF HEALTH

DEPT. OF HEALTH

DEPT. OF HEALTH

DEPT. OF HEALTH

DEPT. OF HEALTH

DEPT. OF HEALTH

DEPT. OF HEALTH

DEPT. OF HEALTH

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 CHARLES RICHARD WILLIAMS, Student Embalmer No. 693

working under my personal supervision.

Student Charles R. Williams
Signature of Student Embalmer

Signed George H. Green

Licensed Embalmer No. 42-20

P. O. Address Fulton, 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.