

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-006612

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1064

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED MAR 8 1963

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Length of stay in 7b 4 yrs.	c. CITY OR TOWN KANSAS CITY Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BAPTIST MEMORIAL HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1183 EAST 77th ST. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First MARY Middle G. Last HARRIS	4. DATE OF DEATH Month FEBRUARY Day 15 Year 1963
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH 12-25-1880	9. AGE (last birthday) 82 years	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED RETAIL GROCER	10b. KIND OF BUSINESS OR INDUSTRY RETAIL GROCERIES	11. BIRTHPLACE (City and state or country) PALMYRA, MISSOURI	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME ALBERT G. ANDERSON	13b. MOTHER'S MAIDEN NAME SARAH ELIZABETH BROWN	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO.	17. INFORMANT Richard L. Eaton, 9800 Wornall Rd, K.C. Mo	Address
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18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular Accident	INTERVAL BETWEEN ONSET AND DEATH 7 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebral arteriosclerosis	3 years
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
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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.)
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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
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21. I attended the deceased from 2-5-63 to 2-15-63 and last saw her/him alive on 2-15-63 Death occurred at 5:15 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Doctor or other) Waldo S. Holt	22b. ADDRESS 2520 Nichols Parkway Kansas City, Mo	22c. DATE SIGNED 2/16/63
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23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 2-18-1963	23c. NAME OF CEMETERY OR CREMATORY MEMORIAL PARK CEMETERY	23d. LOCATION (City, town, or county) (State) KANSAS CITY, MISSOURI
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24. FUNERAL DIRECTOR MUEHLEBACH, 6800 TROOST, K. C. MO.	25. DATE RECD. BY LOCAL REG. 2-18-63	26. REGISTRAR'S SIGNATURE Ruth Long
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(Licensed Embalmer's Statement on Reverse Side)

VS 300 Rev. 4/59
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2 3908
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DATE AMENDED
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF
SHOULD READ
BY AFFIDAVIT OF
Waldo S. Holt
MEDICAL CERTIFICATION

USE BLACK INK OR TYPEWRITER RIBBON

1954

STATE OF MISSOURI

DEPARTMENT OF HEALTH

STATE OF MISSOURI
DEPARTMENT OF HEALTH
BUREAU OF HEALTH SERVICES
DIVISION OF ANATOMY

Dr. Waldos S. Hook
4620 Nichols Drive
St. Joseph, Mo. 64501
will drop by here
not in office Sat
Hall Hospital

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.

MISSOURI DEPARTMENT OF HEALTH BUREAU OF HEALTH SERVICES DIVISION OF ANATOMY

STATE OF MISSOURI DEPARTMENT OF HEALTH BUREAU OF HEALTH SERVICES DIVISION OF ANATOMY