

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-007162

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1339 STATE FILE NUMBER

FILED MAR 15 1963

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

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 MORGAN	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Length of stay in 1b 2 1/2 Mo.	c. CITY OR TOWN VERSAILLES Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LUKE'S HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First JOHN Middle G. Last WITTEN			4. DATE OF DEATH Month FEBRUARY Day 27 Year 1963
5. SEX MALE	6. COLOR OR RACE CAUC.	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12-29-1883
9. AGE (last birthday) 79		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY RETIRED	11. BIRTHPLACE (City and state or country) VERSAILLES, MO.
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME JOHN M. WITTEN	
13b. MOTHER'S MAIDEN NAME SARAH WRAY		14. NAME OF HUSBAND OR WIFE EUNICE WITTEN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) NO		16. SOCIAL SECURITY NO. 16	
17. INFORMANT JOHN II. WITTEN, KANSAS CITY, MO.		18. CAUSE OF DEATH (Enter only one cause per item) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular disease Interval between ONSET AND DEATH years Conditions, if any, which gave rise to above cause (a), stating the underlying cause last: DUE TO (b) _____ DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Fracture, left hip			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 type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) Fell at place of residence 2-14-63	
20c. TIME OF INJURY Hour 4 p.m. Month, Day, Year 2-14-63	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.) Home	20f. CITY, TOWN, OR LOCATION Kansas City, Jackson, Mo.
21. I attended the deceased from 12-15-62 to 2-27-63 and last saw him alive on 2-26-63 . Death occurred at 2:53 A. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) A. Slentz M.D.		22b. ADDRESS 4320 Wornall Rd. N.C., Mo.	22c. DATE SIGNED 2-27-63
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE FEB 27 1963	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) VERSAILLES, MO.
24. FUNERAL DIRECTOR J.W. NEWCOMER'S SONS, KANSAS CITY, MO.		25. DATE RECD. BY LOCAL REG. 2-27-63	26. REGISTRAR'S SIGNATURE Ruth Long

USE BLACK INK OR TYPEWRITER RIBBON

BY AFFIDAVIT OF

9.00
W. T. Miller's Hospital
0404

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 Gen. Michael

Licensed Embalmer No. 4340

P. O. Address K. E. SMO.

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.