

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-011990

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1904 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB
 AMENDED

VS 300
 Rev. 4/59

1
 23 8 6 6 2

3

4 1

5 1

6

7 1

8 1

9 332X

10

11

12 66-0

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

BY AFFIDAVIT OF Blaine Z. Hibbard MEDICAL CERTIFICATION

FILED APR 4 1963	
1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>	
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u> Length of stay in 1b <u>45 YEARS</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. LUKE'S HOSPITAL</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. STREET ADDRESS (if outside, give location) <u>6821 EDGEVALE ROAD</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First Middle Last <u>IRENE GOLDIE WHETSTINE</u>	
4. DATE OF DEATH Month Day Year <u>MARCH 24 1963</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>
7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12-5-1911</u>
9. AGE (last birthday) <u>51</u>	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) <u>HOMEMAKER</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>
11. BIRTHPLACE (City and state or country) <u>AUBURN, NEBRASKA</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>STARNES MCINIKH</u>	13b. MOTHER'S MAIDEN NAME <u>NELLIE ALVA PLASTERS</u>
14. NAME OF HUSBAND OR WIFE <u>JOHN WHETSTINE</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>	
17. INFORMANT Address <u>JOHN WHETSTINE, 6821 EDGEVALE RD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis left internal carotid</u> DUE TO (b) <u>arterio sclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown INTERVAL BETWEEN ONSET AND DEATH <u>5 1/2 days</u> <u>1 year</u>	
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	
21. I attended the deceased from <u>17 May 1955</u> to <u>24 March 1963</u> and last saw her/him alive on <u>23 March 1963</u> Death occurred at <u>5:20 A</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>Blaine Z. Hibbard MD</u>	22b. ADDRESS <u>4320 Wainall Rd. KCMo</u>
22c. DATE SIGNED <u>25 Mar 63</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>MARCH 26, 1963</u>
23c. NAME OF CEMETERY OR CREMATORY <u>MEMORIAL PARK CEMETERY</u>	
23d. LOCATION (City, town, or county) (State) <u>KANSAS CITY MISSOURI</u>	
24. FUNERAL DIRECTOR <u>D.W. NEWCOMER'S SONS, KANSAS CITY, MO.</u>	25. DATE RECD. BY LOCAL REG. <u>3-25-63</u>
26. REGISTRAR'S SIGNATURE <u>Oruth Long</u>	

W. Blaine Park Memorial
Route # 286 - 4320 Marshall Road
1:00-5:00 W

023

023

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

Harold P. Reich

Licensed Embalmer No. *4998*

P. O. Address *K. E., 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.