

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**63-019453**  
STATE FILE NUMBER

Registration District No. 72 Primary Registration District No. 3013 Registrar's No. 119

DO NOT WRITE  
ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

1 6004

2 6008

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4 0

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94201

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11

12 92-3

13 2-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
INSTEAD OF

ITEM NO. SHOULD READ

USE BLACK INK  
OR  
TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

<b>FILED MAY 20 1963</b>		1. PLACE OF DEATH a. COUNTY <u>CLAY</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>CLAY</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>NORTH KANSAS CITY</u>		Length of stay in 1b <u>D.O.A.</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) HOSPITAL OR INSTITUTION <u>North Kansas City Memorial Hospital</u>		d. STREET ADDRESS <u>4819 N. WHEELING</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HARVEY</u> Middle <u>EARL</u> Last <u>SHAW</u>			4. DATE OF DEATH Month <u>MAV</u> Day <u>17</u> Year <u>63</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</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>12/9/97</u>	9. AGE (last birthday) <u>65</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Building Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>KANSAS CITY, MO</u>	
13a. FATHER'S NAME <u>CHARLES F. SHAW</u>		13b. MOTHER'S MAIDEN NAME <u>ELSIE MAY NELSON</u>		14. NAME OF HUSBAND OR WIFE <u>OLIVE SHAW</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.		17. INFORMANT Address <u>Mrs. Olive Shaw, 4819, N. Wheeling</u>	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Don't know Probable Int. Coronary Occlusion</u> DUE TO (b) <u>OCCLUSION</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 type="checkbox"/> No <input type="checkbox"/> Unknown	
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.)	
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	
21. I attended the deceased from _____, to _____ and last saw her/him alive on _____. Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>[Signature]</u> (Degree or title)		22b. ADDRESS <u>North Kansas City, Mo.</u>		22c. DATE SIGNED <u>5/18/63</u> (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>5/27/63</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FOREST HILL</u>	
23d. LOCATION (City, town, or county) <u>KANSAS CITY</u>		MO			
24. FUNERAL DIRECTOR <u>Melody-McGilley-Eular</u>		ADDRESS <u>Antioch Chapel</u>		25. DATE RECD. BY LOCAL REG. <u>5-18-63</u>	
26. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

3325 Vivion Rd, K.C. 19, Mo (Licensed Embalmer's Statement on Reverse Side)

MAY 24 1963  
JUN 3 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 James E. Wacklesman

Licensed Embalmer No. 4573

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.