

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**63-028678**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4207 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

**FILED AUG 14 1963**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>JACKSON</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u> Length of stay in lb <u>2 WEEKS</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BAPTIST MEM. Hosp.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>KANSAS</u> b. COUNTY <u>JOHNSON</u> c. CITY OR TOWN <u>LEAWOOD</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>9004 PAWNEE</u> Residence on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
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<b>3. NAME OF DECEASED</b> (Type or print) First <u>BARD</u> Middle <u>L.</u> Last <u>STEPHENS</u> <b>4. DATE OF DEATH</b> Month <u>JULY</u> Day <u>25</u> Year <u>1963</u>			<b>5. SEX</b> <u>MALE</u> <b>6. COLOR OR RACE</b> <u>WHITE</u> <b>7. Married</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>10/20/1918</u> <b>9. AGE (last birthday)</b> <u>44</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>FARMING AND ACCOUNTING</u> <b>13a. FATHER'S NAME</b> <u>CLAUDE A. STEPHENS</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>ACCOUNTING</u> <b>13b. MOTHER'S MAIDEN NAME</b> <u>RUTH SUSAN WAGNER</u>		
<b>11. BIRTHPLACE</b> (City and state or country) <u>McCRACKEN KANSAS</u> <b>12. CITIZEN OF WHAT COUNTRY</b> <u>USA</u>		<b>14. NAME OF HUSBAND OR WIFE</b> <u>KATHRYN STEPHENS</u>		

<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES WORLD WAR II</u>	<b>16. SOCIAL SECURITY NO.</b> <u>[REDACTED]</u> <b>17. INFORMANT</b> <u>9004 PAWNEE Mrs. KATHRYN STEPHENS, Leawood, Kans.</u>
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<b>18. CAUSE OF DEATH</b> (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Squamous cell carcinoma of lung</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>
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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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<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of Item 18.)
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____		

<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b> _____ <b>COUNTY</b> _____ <b>STATE</b> _____
<b>21. I attended the deceased from</b> <u>8/4/61</u> to <u>7/25/63</u> and last saw him alive on <u>7/24/63</u> Death occurred at <u>6:00</u> <u>A.</u> m. on the date stated above, and to the best of my knowledge, from the causes stated.		

<b>22a. SIGNATURE</b> (Degree or title) <u>Wilson H. Miller, M.D.</u>	<b>22b. ADDRESS</b> <u>3626 Independence Ave Kansas City, Mo. 64124, Mo.</u>	<b>22c. DATE SIGNED</b> <u>7/26/63</u>
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<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>REMOVAL</u>	<b>23b. DATE</b> <u>JULY 27 1963</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>SUNNY SLOPE CEMETERY</u>	<b>23d. LOCATION</b> (City, town, or county) (State) <u>RICHMOND MISSOURI</u>
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<b>24. FUNERAL DIRECTOR</b> <u>D. W. NEWSOMERS SONS, K.C. MO.</u>	<b>25. DATE RECD. BY LOCAL REG.</b> <u>7-26-63</u>	<b>26. REGISTRAR'S SIGNATURE</b> <u>Ruth Long</u>
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(Licensed Embalmer's Statement on Reverse Side)

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DATE AMENDED  
INSTEAD OF  
SHOULD READ  
ITEM NO.

DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF  
Wilson H. Miller

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

W. Wilson Kinnick Miller  
3626 Independence Avenue  
11:00-5:00 PM  
0-1-4  
No.

**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 Kay

Licensed Embalmer No. 4182

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.