

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-032344

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4388 STATE FILE NUMBER

FILED AUG 20 1963

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

BY AFFIDAVIT OF **William R. Brown** MEDICAL CERTIFICATION

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) Kansas City		Length of stay in 1b 28 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 Trinity Lutheran Hosp		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 3410 Cypress Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Lorena Middle M. Last McCormick		4. DATE OF DEATH Month Aug Day 4 Year 1963	
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11-26-1905
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	9. AGE (last birthday) 57 IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HR: Hours _____ Min. _____
11. BIRTHPLACE (City and state or country) Cottonwood Falls, Kansas		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME John T. Crouthers		13b. MOTHER'S MAIDEN NAME Ethel Hickman	14. NAME OF HUSBAND OR WIFE Myron B. McCormick
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 Myron B. McCormick, 3410 Cypress,		Address RC Mo	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema - Acute DUE TO (b) Cerebral Edema + Hypoxia - DUE TO (c) Repeated Convulsions - Status Epilept.		INTERVAL BETWEEN ONSET AND DEATH 4 1/2 HRS. 6 HRS. 6 HRS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) MITRAL STENOSIS		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	
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 4 Aug 63 - 4 PM to 4 Aug 63 9 PM and last saw her alive on 4 Aug 63 Death occurred at 9:2 PM on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree title) William R. Brown M.D.		22b. ADDRESS PRAIRIE VILLAGE, MO 7501 MISSION Rd.	22c. DATE SIGNED 6 Aug 63
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 8-8-1963	23c. NAME OF CEMETERY OR CREMATORY La Harpe Cemetery	23d. LOCATION (City, town, or county) (State) La Harpe, Kansas
24. FUNERAL DIRECTOR ADDRESS Floral Hills Funeral Home Kansas City, Missouri		25. DATE RECD. BY LOCAL REG. 8-6-63	26. REGISTRAR'S SIGNATURE Ruth Long

On Wm Brown
 301 Madison Rd
 Dec 1-27-40
 Dr. C. H. T. Jackson
 306 E. 21st Ave. Wash DC
 Mr. G. O. Hays
 No 2-5011

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 C. M. Jones

Licensed Embalmer No. 3153

P. O. Address W. C. Lane

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.