

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-036475

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4896

DO NOT WRITE ON THIS STUB

AMENDED

FILED SEP 23 1963

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		c. CITY OR TOWN KANSAS CITY	
Length of stay in 1b 50 YEARS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION CREST HAVEN NURSING HOME 3516 SUMMIT STREET		d. STREET ADDRESS (If outside, give location) 808 E. 44th STREET	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) ROBERT MONTGOMERY STAKER			4. DATE OF DEATH SEPTEMBER 3 1963												
5. SEX MALE		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 8-9-1883		9. AGE (last birthday) 80		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED				10b. KIND OF BUSINESS OR INDUSTRY ADVERTISING				11. BIRTHPLACE (City and state or country) CLAYTON, ILLINOIS				12. CITIZEN OF WHAT COUNTRY U.S.A.			
13a. FATHER'S NAME JAMES LILLIS STAKER				13b. MOTHER'S MAIDEN NAME JANE ELIZABETH MONTGOMERY				14. NAME OF HUSBAND OR WIFE MILDRED CAMPBELL STAKER				Address PRAIRIE VILLAGE, ILL.			
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 JAMES STAKER, 8000 DEARBORN DRIVE							

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial pneumonia												INTERVAL BETWEEN ONSET AND DEATH 3 days	
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)										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 KANSAS CITY				COUNTY MISSOURI		STATE	
21. I attended the deceased from 1956 to 9-3-63 and last saw him alive on 8-10-63 Death occurred at 10:15 A. m on the date stated above, and to the best of my knowledge, from the causes stated.															
22a. SIGNATURE Albert J. Decker, M.D.						22b. ADDRESS Kansas City, Mo.				22c. DATE SIGNED 9-3-63					
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION				23b. DATE SEPT. 5, 1963		23c. NAME OF CEMETERY OR CREMATORY NEWCOMER'S CREMATORY				23d. LOCATION (City, town, or county) (State) KANSAS CITY MISSOURI					
24. FUNERAL DIRECTOR D.W. NEWCOMER'S SONS, KANSAS CITY, MO.						25. DATE RECD. BY LOCAL REG. 9-5-63		26. REGISTRAR'S SIGNATURE Bessie Smith							

VS 300 Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF **Albert J. Decker, M.D.**

USE BLACK INK OR TYPEWRITER RIBBON

Dr. Albert Stecker
4706 Broadway

8/2/84
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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 *Edmund M. Denny*
Licensed Embalmer No. 3566

P. O. Address *Memphis City, 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.