

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-036579

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4920 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF
James E. Vaughn MEDICAL CERTIFICATION

FILED SEP 23 1963	
<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>JACKSON</u></p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u> Length of stay in 1b <u>29 YEARS</u></p> <p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>NEUROLOGICAL HOSPITAL</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u></p> <p>c. CITY OR TOWN <u>KANSAS CITY</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>d. STREET ADDRESS (if outside, give location) <u>4826 ROANOKE PARKWAY</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>
<p>3. NAME OF DECEASED (Type or print) First <u>GENEVIEVE</u> Middle <u>WRIGHT</u> Last <u>WRIGHT</u></p>	
<p>4. DATE OF DEATH <u>SEPTEMBER 6 1963</u> Month <u>SEPTEMBER</u> Day <u>6</u> Year <u>1963</u></p>	
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>12/25/1881</u>
9. AGE (last birthday) <u>81</u>	IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>
11. BIRTHPLACE (City and state or country) <u>KIRKSVILLE, MISSOURI</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>JOHN PROBST</u>	13b. MOTHER'S MAIDEN NAME <u>BELLE VARHEAVES</u>
14. NAME OF HUSBAND OR WIFE <u>DR. QUINCY R. WRIGHT</u>	Address <u>4826 ROANOKE PKWY. KANSAS CITY, MISSOURI</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) <u>No</u>	16. SOCIAL SECURITY NO. <u>-----</u>
17. INFORMANT <u>DR. QUINCY R. WRIGHT</u>	Address <u>4826 ROANOKE PKWY. KANSAS CITY, MISSOURI</u>
<p>18. CAUSE OF DEATH (Enter only one cause per line)</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p style="text-align: center;">IMMEDIATE CAUSE (a) <u>Cerebral thrombosis due to arteriosclerosis, sight unknown</u></p> <p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Chronic Brain Syndrome assoc with cerebral arteriosclerosis</u></p> <p>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</p>	
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 <u>6/14/61</u> to <u>9/5/63</u> and last saw ^{her} alive on <u>9/5/63</u>	
Death occurred at <u>5:30 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>James E. Vaughn MD</u>	22b. ADDRESS <u>2625 W. PASCO NC MO</u>
22c. DATE SIGNED <u>9/6/63</u> (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>SEPT. 9, 1963</u>
23c. NAME OF CEMETERY OR CREMATORY <u>MAPLE HILL CEMETERY</u>	23d. LOCATION (City, town, or county) <u>KIRKSVILLE MISSOURI</u>
24. FUNERAL DIRECTOR <u>D.W. NEWCOMER'S SONS</u> ADDRESS <u>1331 BRUSH CREEK KANSAS CITY, MO.</u>	25. DATE RECD. BY LOCAL REG. <u>9-6-63</u>
26. REGISTRAR'S SIGNATURE <u>Bessie Smith</u>	

USE BLACK INK OR TYPEWRITER RIBBON

011000-0-01

26 James Vaughan
2625 N 1st Park - Neurological Hospital
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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 *William M. King*
Licensed Embalmer No. 3566

P. O. Address Kansas 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.