

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-039887
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5779

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>JACKSON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u>		Length of stay in 1b <u>1 YEAR</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>TRINITY LUTHERAN HOSPITAL</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>2233 BRIGHTON AVE</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>TANA</u> Middle <u>H.</u> Last <u>ENCOE</u>			4. DATE OF DEATH Month <u>OCTOBER</u> Day <u>29</u> Year <u>1963</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6/9/1891</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OPERATOR - ROOMING HOUSE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>2106 WEST 39TH ST.</u>	11. BIRTHPLACE (City and state or country) <u>STOCKTON MISSOURI</u>
13a. FATHER'S NAME <u>ALBERT HENDERSON</u>		13b. MOTHER'S MAIDEN NAME <u>MARY MELINDA GRAY</u>	14. NAME OF HUSBAND OR WIFE <u>WALLACE H. ENCOE</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. [REDACTED]	17. INFORMANT Address <u>2233 BRIGHTON KANSAS CITY MO.</u> <u>MRS MARY STRATTON</u>
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Hemorrhage</u> DUE TO (b) <u>Pulmonary Fibrosis</u> DUE TO (c) <u>Probable Tuberculosis - Chronic</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO ABOVE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.			INTERVAL BETWEEN ONSET AND DEATH <u>10-20-63</u> <u>380 yr</u> <u>60 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>arterio-sclerotic disease - Brain</u>			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 (If terminal 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>1955</u> to <u>Oct-23-63</u> and last saw her/him alive on <u>Oct-23-63</u> Death occurred at <u>5:25 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Don Carlos Peete MD</u>		22b. ADDRESS <u>1103 Grand Ave</u>	22c. DATE SIGNED <u>10-24-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>OCT. 26, 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SUNNY SLOPE CEMETERY</u>
23d. LOCATION (City, town, or county) <u>RICHMOND</u>		23e. STATE <u>MISSOURI</u>	
24. FUNERAL DIRECTOR <u>D.W. NEWCOMER'S SONS</u>		ADDRESS <u>1351 BRUSH CREEK KANSAS CITY MO</u>	25. DATE RECD. BY LOCAL REG. <u>10-25-63</u>
26. REGISTRAR'S SIGNATURE <u>Beaie Smith</u>			

USE BLACK INK OR TYPEWRITER RIBBON

Dr. Dean Carlos Post
Trinity Hospital - Highland Ave
1108 - 09

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 Eldon Norris Student Embalmer No. 700

working under my personal supervision.

Student Eldon Norris
Signature of Student Embalmer

Signed Dean W. Huff

Licensed Embalmer No. 4914

P. O. Address Indy, 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.