

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-039976

5486

STATE FILE NUMBER

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

FILE OCT 24 1963

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

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION
BY AFFIDAVIT OF J.P. McCalla

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Jackson</u>	
b. CITY (if outside corporate limits, give TOWNSHIP only), OR TOWN <u>K. C. Mo Kansas City</u> Length of stay in 1b <u>-</u>		c. CITY OR TOWN <u>K. C. Mo Kansas City</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Jackson County Hosp.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>RR3</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Inez</u> Middle _____ Last <u>Jones</u>			4. DATE OF DEATH Month <u>10</u> Day <u>8</u> Year <u>1963</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> <u>unk.</u>	8. DATE OF BIRTH <u>unknown</u>
9. AGE (last birthday) <u>unknow 58</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>UNKOWN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>UNKOWN</u>	11. BIRTHPLACE (City and state or country) <u>UNKOWN</u>
12. CITIZEN OF WHAT COUNTRY _____		13a. FATHER'S NAME <u>UNKOWN</u>	
13b. MOTHER'S MAIDEN NAME <u>UNKOWN</u>		14. NAME OF HUSBAND OR WIFE <u>UNKOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <u>JACKSON COUNTY HOSPITAL</u>		Address _____	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis Generalized</u>			INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>
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 _____	COUNTY _____ STATE _____
21. I attended the deceased from <u>4-28-63</u> to <u>10-8-63</u> and last saw her alive on <u>10-7-63</u> Death occurred at <u>2:25 a.m.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>J.P. McCalla, M.D.</u>		22b. ADDRESS <u>Jackson Co. Hospital Kansas City Mo.</u>	22c. DATE SIGNED <u>10-8-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>ANATOMICAL</u>	23b. DATE <u>10-11-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>K. C. Dental College</u>	23d. LOCATION (City, town, or county) (State) <u>5100 Rockhill Rd.</u>
24. FUNERAL DIRECTOR <u>Kerford Funeral Home</u>		ADDRESS _____	25. DATE RECD. BY LOCAL REG. <u>10-10-63</u>
		26. REGISTRAR'S SIGNATURE <u>Bessie Smith</u>	

X2

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 *Chas. Ernest Hayward*

Licensed Embalmer No. 4437

P. O. Address *2010*

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.