

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-043262

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 72 Primary Registration District No. 3013 Registrar's No. 256

FILED DEC 12 1963

VS 300
Rev. 4/59

16004
27003

3
4 0
5 1
6
7 1
8 2
9 9/108
10 46
11 600
12 90-3
13 20

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

USE BLACK INK
OR
TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY Clay		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) North Kansas City		Length of stay in 1b 5 Hours	c. CITY OR TOWN Raytown
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1711 Swift		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 10604 E. 65th Terr.
3. NAME OF DECEASED (Type or print) First Earl Middle Scott Last Wright		4. DATE OF DEATH Month December Day 6 Year 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 8-22-1919
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Machine Company	11. BIRTHPLACE (City and state or country) Leavenworth Co. Ks
13a. FATHER'S NAME James G. Wright		13b. MOTHER'S MAIDEN NAME Bessie E. Perry	14. NAME OF HUSBAND OR WIFE Loretta Ann Wright
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. [REDACTED]	
17. INFORMANT Loretta Wright		Address Raytown, Mo. 10604 E 65th Terr	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed chest & neck injuries DUE TO (b) High Loader bucket fell on back DUE TO (c) Accidental release of bucket			INTERVAL BETWEEN ONSET AND DEATH 50.1.
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 checked="" 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 <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. Month, Day, Year		20d. INJURY OCCURRED WHILE AT WORK <input checked="" 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.) 1711 Swift		20f. CITY, TOWN, OR LOCATION North Kansas City, Mo.	COUNTY Clay STATE Mo.
21. I attended the deceased from _____ to _____ and last saw him/her alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Dr. O. H. Pate M.D. (Coroner)		22b. ADDRESS North Kansas City, Mo.	22c. DATE SIGNED 12/6/1963
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12-9-1963	23c. NAME OF CEMETERY OR CREMATORY Floral Hills	23d. LOCATION (City, town, or county) (State) Kansas City, Missouri
24. FUNERAL DIRECTOR Floral Hills Funeral Home		25. DATE RECD. BY LOCAL REG. 12-7-63	26. REGISTRAR'S SIGNATURE Marguerite Hudgens

(Licensed Embalmer's Statement on Reverse Side)

DEC 13 1963

JAN 2 1964

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 E. M. Joiner

Licensed Embalmer No. 3453

P. O. Address H. E. Han.

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.