

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-043988
STATE FILE NUMBER

DO NOT WRITE ON THIS STUD

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6262

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		Length of stay in lb 53 Years	c. CITY OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Baptist Mem. Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4200 E. 59th St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) MARQUIS A HIBBS			4. DATE OF DEATH Month Nov. Day 17 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 3-13-86	9. AGE (last birthday) 77	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ass't Treasurer		10b. KIND OF BUSINESS OR INDUSTRY K.C. Title & Trust		11. BIRTHPLACE (City and state or country) Adams County, Ohio	12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME William Hibbs		13b. MOTHER'S MAIDEN NAME Virginia Murfin		14. NAME OF HUSBAND OR WIFE Katherine P. Hibbs	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) No		16. SOCIAL SECURITY NO. [REDACTED]	17. INFORMANT Address Katherine Hibbs 4200 E. 59th K.C. Mo.		
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO (b) Coronary Vascular Sclerosis DUE TO (c) Senile changes PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Myocardial Failure 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 March 1986 and last saw him alive on 11-16-63 . Death occurred at 6:15 AM 11-17-63 on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) D. M. Shapiro MD			22b. ADDRESS 701063 Sent 201		22c. DATE SIGNED 11-18-63
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Nov 19, 1963	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION (City, town, or county) (State) Kansas City, Mo.		
24. FUNERAL DIRECTOR Melody McGilley Eylar		ADDRESS 20 W. Linwood	25. DATE RECD. BY LOCAL REG. 11-18-63	26. REGISTRAR'S SIGNATURE Bessie Smith	

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

M. Shapiro

Dr L M Shapiro
701 E 63

H1-4-2022

1:30 - 5 PM

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 April J. Dickerson

Licensed Embalmer No. 5120

P. O. Address KE 11, 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.