

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-29863-048318  
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6329

**FILED DEC 19 1963**

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in 1b <b>48 yrs.</b>	c. CITY OR TOWN <b>Kansas City</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Leeds Sanitatum</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>5609 Virginia Ave.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) <b>Fritz Rasee White, Sr.</b>			4. DATE OF DEATH <b>November 18, 1963</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>3/31/1885</b>	9. AGE (last birthday) <b>78</b>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railway</b>		11. BIRTHPLACE (City and state or country) <b>U. S. A.</b>	
13a. FATHER'S NAME <b>Joseph White</b>		13b. MOTHER'S MAIDEN NAME <b>Dora Rasee</b>		14. NAME OF HUSBAND OR WIFE <b>Gladys White</b> d/d- <b>1935</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>		17. INFORMANT <b>11209 Norton, Kansas City, Missouri</b> <b>Mrs. Hollis White</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Pulmonary Tuberculosis</b>		<b>6 weeks</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Tuberculous Meningitis</b>	<b>6 weeks</b>
	DUE TO (c) <b>Miliary Tuberculosis</b>	<b>6 weeks</b>
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 <b>11/18/63</b>	COUNTY <b>11/18/63</b>	STATE
21. I attended the deceased from <b>11/9/63</b> to <b>11/18/63</b> and last saw him alive on <b>11/18/63</b> . Death occurred at <b>9:30 pm</b> on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE <i>D. W. Newcomer</i>	(Degree or title)	22b. ADDRESS <b>314 Park Blvd., K. Mo.</b>	22c. DATE SIGNED <b>11/18/63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>11/21/63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Moriah Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Kansas City, Missouri</b>
24. FUNERAL DESIGNS <b>D. W. Newcomer's Sons K. C., Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>12-11-63</b>	26. REGISTRAR'S SIGNATURE <i>Bessie Smith</i>

VS 300 Rev. 4/59	AMENDED	DATE AMENDED	ITEM NO.	SHOULD READ	MEDICAL CERTIFICATION	DOCUMENT	BY AFFIDAVIT OF
1							
2		2					
3							
4		0					
5		2					
6							
7		1					
8		2					
9		0021					
10							
11							
12		86-0					
13							

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

BY AFFIDAVIT OF

*A. N. N. Buckenham -  
314 Professional Bldg  
Ryde*

**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 *Wern Lawler*

Licensed Embalmer No. 4915

P. O. Address *KC 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.