

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-036110

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4828

DO NOT WRITE ON THIS STUB

AMENDED

FILED SEP 18 1963

VS 300	DATE AMENDED
Rev. 4/59	
1	
2 <u>0425</u>	
3	
4 <u>1</u>	
5 <u>1</u>	
6	
7 <u>0</u>	
8 <u>2</u>	
9 <u>170X</u>	
10	
11	
12 <u>65-0</u>	
13	

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>Jackson</u>		a. STATE <u>Missouri</u> b. COUNTY <u>Henry</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		c. CITY OR TOWN <u>Clinton</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Length of stay in 1b <u>1 day</u>		d. STREET ADDRESS (If outside, give location) <u>719 East Jefferson</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mrs. LETA MAE EVERSOLE</u>		4. DATE OF DEATH Month Day Year <u>August 31, 1963</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5-3-1918</u>
9. AGE (last birthday) <u>45</u>		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ben Franklin Store</u>	11. BIRTHPLACE (City and state or country) <u>Brownington, Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>U. S.</u>		13a. FATHER'S NAME <u>Sam Walters</u>	
13b. MOTHER'S MAIDEN NAME <u>Margaret Kelly</u>		14. NAME OF HUSBAND OR WIFE <u>Darl Eversole</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. <u>488-32-7758</u>	17. INFORMANT <u>Darl Eversole</u> Address <u>719 E. Jefferson</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Breast & Cerebral Metastases</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 years</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 checked="" 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 s.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>Feb 10, 1960</u> to <u>Present</u> and last saw her/him alive on <u>August 30, 1963</u> 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) <u>Ralph Mac Knight M.D.</u>		22b. ADDRESS <u>1010 Prof. Bldg., K.C., Mo.</u>	22c. DATE SIGNED <u>8-31-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>Aug. 31, 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Maple Wood</u>	23d. LOCATION (City, town, or county) (State) <u>Clinton, Missouri</u>
24. FUNERAL DIRECTOR ADDRESS <u>Stine & McClure - K. C., Missouri</u>		25. DATE RECD. BY LOCAL REG. <u>9-1-63</u>	26. REGISTRAR'S SIGNATURE <u>Bessie Smith</u>

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

Dr. Eugene McLaughlin, M.D.
1010 Craig Blvd.
Ha 1-4565
Craig - Ft. Jones. 022 a.m.

FEB 4 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 *J. Swalters*

Licensed Embalmer No. 2744

P. O. Address K.C.M.D.

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.