

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **37613**
4211
Registrar's No.

Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No.

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Kansas City, Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Lakeside Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 days**
(Specify whether
In this community **26 years**
(? years, months or days)

FILED DEC 11 1970

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City, Mo.**
(If outside city or town limits write "RURAL")
(d) Street No. **3638 Woodland**
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME **Roy E Andrews**

8. (b) If veteran, name war **None** 3. (c) Social Security No. **486-01-7317**

4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Vivian** 6. (c) Age of husband or wife if alive **27** years

7. Birth date of deceased **April 15th, 1911**
(Month) (Day) (Year)

8. AGE:	Years 26	Months 6	Days 19	If less than one day hr. _____ min.
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9. Birthplace _____ Mo. _____
(City, town, or county) (State or foreign country)

10. Usual occupation **Carrier**

11. Industry or business **K.C. Star**

12. Name **Albert E. Andrews**

13. Birthplace _____ Mo. _____
(City, town, or county) (State or foreign country)

14. Maiden name **Viola Mount**

15. Birthplace _____ Ill _____
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Vivian Andrews**

(b) Address **3638 Woodland, K.C. Mo.**

17. (a) **Burial** (b) Date thereof **Nov. 6th-1970**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Forest Hill**

18. (a) Signature of funeral director **C.H. Blackman & Son, Inc.**

(b) Address _____

19. (a) **11-5-40** (b) **M. M. Crowe**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov.** day **4th**
year **1970** hour **12** minute **30** A. M.

21. I hereby certify that I attended the deceased from **October 30**, 19**70**, to **November 5**, 19**70**
that I last saw him alive on **November 4**, 19**70**
and that death occurred on the date and hour stated above.

Immediate cause of death **Acute glomerular nephritis, toxic myocarditis, edema with complete renal & cardiac failure**

Due to _____
Due to **Acute suppurative appendicitis**
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

(Specify type of place)
While at work? _____ (e) Means of injury **2**
23. Signature **Chas. L. Curry** (M. D. or other) **MD**
Address **609 Chambers Bldg** Date signed **11-4-70**

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEC 30 1947

Dr. Curry, Chambers Bldg.

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

W.D. Blackman

Licensed Embalmer No.....

3639

P. O. Address.....

R.C. 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 this body is not embalmed, above space should be left blank.