

Health,
Welfare
Public
Service

STANDARD CERTIFICATE OF DEATH

31984
STATE FILE NUMBER
3974

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3974

300
1-57

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) OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF DECEASED (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1310 E. Armour Elms Nursing Home		Length of stay in 1b 72 yrs	STREET ADDRESS (If outside, give location) 1310 E. Armour		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First JAY Middle P. Last LAUGHLIN			4. DATE OF DEATH Month Aug Day 23 Year 1957		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 5 1870	9. AGE (In years last birthday) 87	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper		10b. KIND OF BUSINESS OR INDUSTRY Coal co.	11. BIRTHPLACE (City and state or country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Emma Randolph Unknown		14. NAME OF HUSBAND OR WIFE Robert L. Laughlin	
15. WAS DECEASED EVER IN U. S. ARMY, NAVY, AIR FORCE, MARINE CORPS, OR COAST GUARD (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 487-03-6001A		17. INFORMANT Mrs. Robert L. Laughlin, 6136 Tracy	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia Terminal					INTERVAL BETWEEN ONSET AND DEATH 4 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebral Vascular Accident					4 mo
DUE TO (c) Chronic arterio-sclerotic Vascular Disease					331 X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Obesity					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 _____, Month _____, Day _____, Year _____ a.m. _____ p.m. _____					
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 Feb 18 1940 to Aug 23 57 and last saw him alive on Aug 22 1957 Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE Glen H. Proyle (Degree or title) MD			22b. ADDRESS 1232 Professional Bldg.		22c. DATE SIGNED 8-24-57
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 8-26-57	23c. NAME OF CEMETERY OR CREMATORY Mt. Moriah Cemetery		23d. LOCATION (City, town, or county) (State) Kansas City, Missouri
24. FUNERAL DIRECTOR Melody-McGilley-Eylar Funeral Home			25. DATE RECD. BY LOCAL REG. 8-24-57		26. REGISTRAR'S SIGNATURE Neva Minshall

MEDICAL CERTIFICATION
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
Glen H. Proyle

1800 E. Linwood, K. C., Mo. (Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

KP
2

Dr. Bingham
Prof. Blyg.
Ba 1-4420

11-3:30 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 

Licensed Embalmer No.

P. O. Address R.C.

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.