

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-001400

FILED VS FEB 1 1960

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 223 STATE FILE NUMBER

INDEXED

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|--|---|---|--|--|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>JACKSON</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>PLATTE</u> | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u> | | | Length of stay in 1b <u>2 WKS.</u> | | c. CITY OR TOWN <u>PARKVILLE</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>TRINITY LUTHERAN</u> | | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <u>817 SHORE DRIVE</u> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>CLARENCE</u> Middle <u>--</u> Last <u>BLUNT</u> | | | 4. DATE OF DEATH Month <u>JAN.</u> Day <u>13,</u> Year <u>1960</u> | | | | | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</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>4-21-1900</u> | 9. AGE (last birthday) <u>59</u> | IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u> | IF UNDER 24 HR Hours <u>-</u> Min. <u>-</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ASSEMBLER</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>VENDO Co.</u> | | 11. BIRTHPLACE (City and state or country) <u>PLAT RIVER, Mo.</u> | 12. CITIZEN OF WHAT COUNTRY <u>U.S.;A.</u> | | |
| 13a. FATHER'S NAME <u>MATHEW BLUNT</u> | | | 13b. MOTHER'S MAIDEN NAME <u>SARAH COMPTON</u> | | | 14. NAME OF HUSBAND OR WIFE <u>VIRGINIA E. BLUNT</u> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES WW # 11</u> | | | 16. SOCIAL SECURITY NO. <u>486-05-1784</u> | | 17. INFORMANT Address <u>PARKVILLE, Mo.</u> <u>MRS. VIRGINIA BLUNT</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>Pulmonary Thrombo Embolism</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Postoperative Hypotension 36 hrs</u> DUE TO (c) <u>Abdominal Aortic Aneurysm 6 mos</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs</u> <u>6 mos</u> | |
| 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 <u>-</u> a.m. <u>-</u> p.m. <u>-</u> | Month, Day, Year <u>-</u> <u>-</u> <u>-</u> | | 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>Dec-28-1959</u> to <u>Jan-13-60</u> and last saw him live on <u>Jan-12-60</u> Death occurred at <u>8:25</u> a.m. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE (Degree or title) <u>[Signature]</u> | | | | 22b. ADDRESS <u>106 W 14th St KC Mo</u> | | 22c. DATE SIGNED <u>1-13-60</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u> | | 23b. DATE <u>1-16-1960</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>MEMORIAL PARK</u> | | 23d. LOCATION (City, town, or county) (State) <u>DESLOGE, MISSOURI</u> | | | |
| 24. FUNERAL DIRECTOR ADDRESS <u>C. H. BLACKMAN & SON INC. K.C. Mo.</u> | | | | 25. DATE RECD. BY LOCAL REG. <u>1-14-60</u> | | 26. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

W.C. Rennie

Licensed Embalmer No. 487

P. O. Address N.C. M

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.