

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-001768

FILED VS JAN 19 1960/49

Registration District No. 1002 Primary Registration District No. 1002 Registrar's No. 36

STATE FILE NUMBER

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> b. COUNTY <b>Jackøen</b>									
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in 1b <b>55 days</b>		c. CITY OR TOWN <b>Independence</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>Northeast Hospital</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (if outside, give location) <b>313 S. Pleasant</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>CARRIE</b> Middle <b>W.</b> Last <b>MUIR</b>				4. DATE OF DEATH Month <b>Jan</b> Day <b>1</b> Year <b>1960</b>									
5. SEX <b>female</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>1876</b>		9. AGE (last birthday) <b>84</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>		11. BIRTHPLACE (City and state or country) <b>Independence, Mo.</b>			12. CITIZEN OF WHAT COUNTRY <b>USA</b>					
13a. FATHER'S NAME <b>Lampert Williamson</b>				13b. MOTHER'S MAIDEN NAME <b>Rachel L. Unknown</b>				14. NAME OF HUSBAND OR WIFE <b>William Muir</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>Hutchison, Harvey</b>			Address <b>2328 S. Sterling Indep., Mo.</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>Chronic Myocarditis</b>										?			
DUE TO (b) <b>Chronic Interstitial Nephritis</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) <b>Emaciation due to malnutrition</b>										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 Month, Day, Year a.m. p.m.													
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 <b>Nov. 6, 1959</b> to <b>Jan 1, 1960</b> and last saw her <sup>her</sup> alive on <b>Jan 1, 1960</b> Death occurred at <b>11:45 am</b> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <b>Frank E. Day D.O.</b> (degree or title)						22b. ADDRESS <b>4314 29th St. K. Mo. 2-60</b>			22c. DATE SIGNED <b>1-2-60</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>1/5/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>			23d. LOCATION (City, town, or county) (State) <b>Independence, Mo.</b>						
24. FUNERAL DIRECTOR <b>Geo. C. Carson &amp; Sons</b> ADDRESS <b>Independence, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>1-4-60</b>		26. REGISTRAR'S SIGNATURE <b>Neva Minshally</b>							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF Frank E. Day

313 2. 159211

STATE

OF

CERTIFICATE

**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 Dean W. Huff

Licensed Embalmer No. 4914

P. O. Address Indy, 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.