

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-006393

FILED VS FEB 23 1960 149

Registration District No. 1002 Registrar's No. 771

STATE FILE NUMBER

| | | | | | | | | | | | | | |
|---|--|---|---|--|---|--|--|--|--------------------------------|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <i>Jackson</i> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY <i>Jackson</i> | | | | | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Kansas City</i> | | Length of stay in 1b <i>7 1/2 yrs.</i> | | c. CITY OR TOWN <i>Kansas City</i> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | | | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Dr. Osteopathic Hospital</i> | | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <i>4417 Bee</i> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED (Type or print) First <i>Estella</i> Middle <i>Elizabeth</i> Last <i>Knox</i> | | | | 4. DATE OF DEATH Month <i>2</i> Day <i>7</i> Year <i>1960</i> | | | | | | | | | |
| 5. SEX <i>Female</i> | | 6. COLOR OR RACE <i>White</i> | | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH <i>10-11-1871</i> | | 9. AGE (last birthday) <i>88</i> | | IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i> | | IF UNDER 24 HR Hours <i>0</i> Min. <i>0</i> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i> | | 11. BIRTHPLACE (City and state or country) <i>Jackson County Mo.</i> | | 12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i> | | | | | |
| 13a. FATHER'S NAME <i>David Muncy</i> | | | | 13b. MOTHER'S MAIDEN NAME <i>Marinda Griffith</i> | | | | 14. NAME OF HUSBAND OR WIFE <i>Charles W. Knox</i> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i> | | | | 16. SOCIAL SECURITY NO. <i>-</i> | | 17. INFORMANT <i>Jay Knox</i> | | Address <i>4417 Bee H.C. Mo.</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Decompensated myocarditis</i> | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i> | | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>General arteriosclerosis</i> | | | | | | | | | | DUE TO (c) <i>3 yrs.</i> | | | |
| 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 <i>-</i> a.m. <i>-</i> p.m. <i>-</i> | | Month, Day, Year | | 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 <i>Jan. 1, 1958</i> to <i>Feb. 7, 1960</i> and last saw her <i>alive</i> on <i>2/7/60</i> Death occurred at <i>3:30 P.M.</i> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | | | | |
| 22a. SIGNATURE <i>J. J. Pocsik</i> (Degree or title) <i>D.O.</i> | | | | | | 22b. ADDRESS <i>6518 Independence</i> | | | 22c. DATE SIGNED <i>2/8/60</i> | | | | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE <i>2-10-1960</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Green Lawn Cem.</i> | | | 23d. LOCATION (City, town, or county) <i>Kansas City Mo.</i> | | | (State) | | | |
| 24. FUNERAL DIRECTOR <i>C.H. Blackman & Son</i> | | | | | | ADDRESS <i>San Mo. H.C. Mo.</i> | | 25. DATE RECD. BY LOCAL REG. <i>2-9-60</i> | | 26. REGISTRAR'S SIGNATURE <i>Dever Minshall</i> | | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF J. J. Pocsik

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 Bert B. Bend

Licensed Embalmer No. 4656

P. O. Address B.C. 7M

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.