RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-60-015461

FILED VS MAY 5 1960

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2190

STATE FILE NUMBER

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City — Length of stay in 1b 75 yrs
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) General Hospital — Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY Jackson
c. CITY OR TOWN Kansas City — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 1643 Jefferson — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First Ruth — Middle — Last Larrison

4. DATE OF DEATH Month Day Year 4-17-60

5. SEX Female
6. COLOR OR RACE White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH 8-2-84
9. AGE (last birthday) 75 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (City and state or country) Kansas City, Missouri
12. CITIZEN OF WHAT COUNTRY U.S.A

13a. FATHER'S NAME "unknown" Snider
13b. MOTHER'S MAIDEN NAME "unknown"
14. NAME OF HUSBAND OR WIFE Charles E. Larrison

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Records: Jackson County Welfare — Address K.C. Mo.

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) Lobar pneumonia

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (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) Congestive heart failure

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 4-7-60, to 4-17-60 and last saw her/him alive on 4-17-60
Death occurred at 8:57 p m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) H. L. Dwyer MD
22b. ADDRESS 2400 Cherry
22c. DATE SIGNED 4-18-60

23a. [illegible] REMOVAL (Specify) Removal
23b. DATE 4-22-60
23c. NAME OF CEMETERY OR CREMATORY [illegible] Osteopathy & Dentistry
23d. LOCATION (City, town, or county) [illegible] Missouri

24. FUNERAL DIRECTOR Weilert's: 2332 Monitor Place
ADDRESS C. College K.C. Mo.
25. DATE RECD. BY LOCAL REG. 4-19-60
26. REGISTRAR'S SIGNATURE Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT none

BY AFFIDAVIT OF Funeral Home

MEDICAL CERTIFICATION H. L. Dwyer

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_____ Signed R. E. Weibert

Signature of Student Embalmer

Licensed Embalmer No. 4075

P. O. Address R.C.S.M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com
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.