

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-015553

FILED VS MAY 9 1960

149

Primary Registration District No. 1002

Registrar's No.

2257

STATE FILE NUMBER

| | | | | | | | | |
|---|----------------------------------|---|--|--|---|--|---|---------|
| 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 | | | Length of stay in lb 5 years | | c. CITY OR TOWN Kansas City | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR 5900 Swope Parkway INSTITUTION Swope Ridge Nursing Home | | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 5900 Swope Parkway | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Clarence Middle C. Last Outhier | | | | 4. DATE OF DEATH Month April Day 21 Year 1960 | | | | |
| 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 Sept 10, 1875 | 9. AGE (last birthday) 84 | IF UNDER 1 YEAR Months | IF UNDER 24 HR Days | Hours | Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Real Estate Sales | | | 10b. KIND OF BUSINESS OR INDUSTRY Real Estate | | 11. BIRTHPLACE (City and state or country) Hancock Co. Illinois | | 12. CITIZEN OF WHAT COUNTRY U. S. A | |
| 13a. FATHER'S NAME Theopolis Outhier | | | 13b. MOTHER'S MAIDEN NAME Susanna Haycraft | | | 14. NAME OF HUSBAND OR WIFE Gisella Outhier (dec) | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) None | | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Address Mrs. H. R. McGuire 11005 E. 24th Indep. Mo | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilat. Bronchopneumonia DUE TO (b) Senility DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 wk | |
| 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"/> N. <input type="checkbox"/> Unknown | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 _____ a.m. _____ p.m. _____ | | Month, Day, Year | | | | | | |
| 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 10-7-57 to 4-21-60 and last saw him alive on 4-20-60 Death occurred at 5:20 A on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE [Signature] (Degree or title) | | | | 22b. ADDRESS 701 E 63 KC Mo | | | 22c. DATE SIGNED 4-27-60 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE April 23, 1960 | | 23c. NAME OF CEMETERY OR CREMATORY Forest Hill Cemetery | | 23d. LOCATION (City, town, or county) Kansas City, Missouri | | (State) |
| 24. FUNERAL DIRECTOR Muehlebach Funeral Home 6800 Troost | | | | 25. DATE RECD. BY LOCAL REG. 4-22-60 | | 26. REGISTRAR'S SIGNATURE [Signature] | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF Embalmer

Dr. Passman
Doctors Bldg
Ja 3-6575

10:30 AM

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 Claw Carr

Licensed Embalmer No. 4934
P. O. Address KC 14, 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.