

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

LED VS JUN 15 1960

=60-019772

Registration District No. 150 Primary Registration District No. 5572 Registrar's No. 128

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>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Rural Prairie</b>		Length of stay in 1b <b>3 1/2 Mo.</b>	c. CITY OR TOWN <b>Blue Springs</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Jackson County Hosp.</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1501 Sol5th</b>
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Stella</b> Middle <b>÷</b> Last <b>Moad</b>			4. DATE OF DEATH Month <b>June</b> Day <b>2</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>6/9/1866</b>	9. AGE (last birthday) <b>93</b>	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) <b>retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>O A F</b>		11. BIRTHPLACE (City and state or country) <b>Franklin, Indiana</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13a. FATHER'S NAME <b>Mercer Berry</b>		13b. MOTHER'S MAIDEN NAME <b>Mildred Robinson</b>		14. NAME OF HUSBAND OR WIFE <b>Deceased</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 Address <b>Mrs E.A. Ford Blue Springs Mo</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b>				INTERVAL BETWEEN ONSET AND DEATH <b>one hour</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <b>Arteriosclerotic Heart Disease</b>		
		DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) <b>Senile.</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		
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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.)			
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year
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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
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21. I attended the deceased from 5-2-60 to 6-1-60 and last saw her/him alive on 6-1-60.  
Death occurred at 9:05 6-2-60 am on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>J.P. McCalla, M.D.</b>	(Degree or title)	22b. ADDRESS <b>6312 Raytown Rd., Raytown Mo.</b>	22c. DATE SIGNED <b>6-2-60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>June 4 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Belton Cem</b>	23d. LOCATION (City, town, or county) (State) <b>Belton Mo</b>
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24. FUNERAL DIRECTOR <b>Webb Funeral Home Blue Springs Mo</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>June 4-60</b>	26. REGISTRAR'S SIGNATURE <b>M. Langford</b>
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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 William J. [Signature]

Licensed Embalmer No. 473

P. O. Address [Signature]

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