

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 8 1960

=60-027239

Registration District No. 393 Primary Registration District No. 1002 Registrar's No. 3859 STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <u>Clay County</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Clay</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City North</u>		Length of stay in lb <u>30 years</u>		c. CITY OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>3507dg. W. of 52nd + N. Oak</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>3137 Wheeling</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Leo</u> Middle <u>John</u> Last <u>Youck</u>				4. DATE OF DEATH Month <u>7</u> Day <u>24</u> Year <u>60</u>									
5. SEX <u>male</u>		6. COLOR OR RACE <u>White</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>9/25 1899</u>		9. AGE (last birthday) <u>60</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HR Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saborer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>apparel dealing</u>			11. BIRTHPLACE (City and state or county) <u>Arapahoe Neb.</u>			12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>				
13a. FATHER'S NAME <u>Loring Youck</u>				13b. MOTHER'S MAIDEN NAME <u>Alaisia Brauner</u>				14. NAME OF HUSBAND OR WIFE <u>Una De Wolf</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes W. W. II</u>				16. SOCIAL SECURITY NO. <u>493-12-7001</u>		17. INFORMANT <u>Una De Wolf</u>				Address <u>3137 Wheeling</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>massive hemorrhage</u> DUE TO (b) <u>Deep Laceration by razor blade</u> <u>left arm cubital vessels</u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.												INTERVAL BETWEEN ONSET AND DEATH	
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 checked="" 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 <u>  </u> a.m. <u>  </u> p.m. <u>  </u> Month, Day, Year <u>  </u> <u>  </u> <u>  </u>													
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 _____, to _____ and last saw her/him alive on _____. Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <u>O S Pate M.D. Crower</u>						22b. ADDRESS <u>North Kansas City, Mo.</u>			22c. DATE SIGNED <u>7/26/60</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>7-27-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Green Lawn</u>			23d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo.</u>						
24. FUNERAL DIRECTOR <u>Sheil Funeral Home</u>				ADDRESS <u>4606 Dodge</u>		25. DATE RECD. BY LOCAL REG. <u>7-26-60</u>		26. REGISTRAR'S SIGNATURE <u>Neve Marshall</u>					

DOCUMENT

MEDICAL CERTIFICATION

O S. Pate

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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed  \_\_\_\_\_

Licensed Embalmer No. 4959

P. O. Address K. C. Mo

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