

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-027314

STATE FILE NUMBER

Registration District No. 150 Primary Registration District No. 5572 Registrar's No. 148

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| 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 Rural Prairie | | Length of stay in lb 1 mo. | c. CITY OR TOWN Lee's Summit Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jackson County Hosp. | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | d. STREET ADDRESS (If outside, give location) Lake Lotawana Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First Elmer Middle L Last Muncy | | | 4. DATE OF DEATH Month July Day 6 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 12/3/1872 | 9. AGE (last birthday) 85 | IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> | IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (retired) | | 10b. KIND OF BUSINESS OR INDUSTRY Farm | | 11. BIRTHPLACE (City and state or country) Missouri | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13a. FATHER'S NAME David Muncy | | | 13b. MOTHER'S MAIDEN NAME Miranda Griffith | | 14. NAME OF HUSBAND OR WIFE Deceased | | |

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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | 16. SOCIAL SECURITY NO. 486-26-0751 | 17. INFORMANT Address Mrs Ray Selvy Blue Springs Mo |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease Unknown DUE TO (b) _____ DUE TO (c) _____ 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 |

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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 6-2-60 to 7-6-60 and last saw her/him alive on 7-5-60
Death occurred at 4:55 A. m on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE J.P. McCalla, M.D. (Degree or title) | 22b. ADDRESS 6312 Raytown Rd., Raytown, Mo. | 22c. DATE SIGNED 7/6/60 (State) |
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|--|---------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE July 8 1960 | 23c. NAME OF CEMETERY OR CREMATORY Blue Springs Cem | 23d. LOCATION (City, town, or county) Blue Springs Mo |
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| 24. FUNERAL DIRECTOR Webb Funeral Home Blue Springs Mo | ADDRESS | 25. DATE RECD. BY LOCAL REG. 7-8-1960 | 26. REGISTRAR'S SIGNATURE J. B. Longford |
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUL 19 1960

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 Frost

Licensed Embalmer No. 4733

P. O. Address Blue Springs

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