URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED 15 AUG 23 1960

60-030495

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4013

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: 2 Hrs
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Childrens Mercy Hospital — Inside Limits Yes [X] No [ ]

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Jackson
c. CITY OR TOWN Grandview — Inside Limits Yes [ ] No [X]
d. STREET ADDRESS (If outside, give location) Route 2 — Reside on Farm Yes [X] No [ ]

3. NAME OF DECEASED (Type or print): First RACHIEL Middle LORRAINE Last COUTS
4. DATE OF DEATH: Month August Day 3 Year 1960
5. SEX: Female
6. COLOR OR RACE: White
7. Married [ ] Never Married [X] Widowed [ ] Divorced [ ]
8. DATE OF BIRTH: Aug 3 1960
9. AGE (last birthday) — IF UNDER 1 YEAR: Months Days — IF UNDER 24 HR: Hours 2 Min. 30
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country): Lees Summit Mo.
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: Earl Couts
13b. MOTHER'S MAIDEN NAME: Virginia Halcombe
14. NAME OF HUSBAND OR WIFE: N ne
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.: None
17. INFORMANT: Earl Couts Address: Grandview Missouri

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bilateral Hemorrhagic Pneumonia
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)
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. [ ] 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 _____, 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 Hughes Owens (Degree or title) Coroner
22b. ADDRESS 152 Union Station
22c. DATE SIGNED 8-5-60

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Aug 6 1960
23c. NAME OF CEMETERY OR CREMATORY: Floral Hills Cemetery
23d. LOCATION (City, town, or county) (State): Kansas City Missouri

24. FUNERAL DIRECTOR: Sheil Funeral Home Kansas City Mo
ADDRESS
25. DATE RECD. BY LOCAL REG.: 8-5-60
26. REGISTRAR'S SIGNATURE: H. L. Dwyer, M.D.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF Hugh H. Owens

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_____ Signed _____

Signature of Student Embalmer

Licensed Embalmer No._____

P. O. Address_____

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.