

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-041957

FILED VS DEC 12 1960

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5760

STATE FILE NUMBER

NDED

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 1b 20 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 INSTITUTION Menorah Medical Center		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4700 Roanoke Pkwy Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Marion Middle Saunders Last Day			4. DATE OF DEATH Month 11 Day 14 Year 60		
---	--	--	--	--	--

5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2/18/1893	9. AGE (last birthday) 67	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <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) SALESMAN	10b. KIND OF BUSINESS OR INDUSTRY AUTOMOBILE	11. BIRTHPLACE (City and state or country) FORT SMITH, ARKANSAS	12. CITIZEN OF WHAT COUNTRY U.S.A.
--	--	---	--

13a. FATHER'S NAME SAUNDERS P. DAY	13b. MOTHER'S MAIDEN NAME ANGLE SWANN	14. NAME OF HUSBAND OR WIFE MRS. LUCILE DAY
--	---	---

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. 510-10-6123	17. INFORMANT MRS. LUCILE DAY Address 4700 ROANOKE PARKWAY KANSAS CITY, 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) Arteriosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 2 years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		

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 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 KANSAS CITY	STATE MISSOURI
---	--	--	--	--------------------------

21. I attended the deceased from July 60 to Nov 14-60 and last saw her/him alive on 11/14/60 Death occurred at 11/14 at 9:30 am on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Olto M Sperry MD	22b. ADDRESS 409 E 63 Street KC Mo	22c. DATE SIGNED 11/16/60
---	--	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE NOV. 16, 1960	23c. NAME OF CEMETERY MT. MORIAH CEMETERY	23d. LOCATION (City, town, or county) (State) KANSAS CITY MISSOURI
--	-----------------------------------	---	--

24. FUNERAL DIRECTOR D.W. NEWCOMER'S SONS KANSAS CITY, MO. ADDRESS 1331 BRUSH CREEK	25. DATE RECD. BY LOCAL REG. 11-16-60	26. REGISTRAR'S SIGNATURE H. L. Dwyer
--	---	---

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Stipulated

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 Chester K Brown

Licensed Embalmer No. 49

P. O. Address KE M

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.