

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-046502

FILED VS DEC 28 1960

Registration District No. 46 Primary Registration District No. 5568 Registrar's No. 619

STATE FILE NUMBER

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| 1. PLACE OF DEATH<br>a. COUNTY <u>Jackson</u> (Blue)   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u> |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>                         |  | Length of stay in 1b <u>40 yrs</u>   | c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>   |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>11311 E. 9th - Inter-City</u> |  | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  | d. STREET ADDRESS (If outside, give location) <u>11311 E 9th - Inter-City</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First <u>Perla</u> Middle <u>Wilde</u> Last <u>Elerick</u> |  |  | 4. DATE OF DEATH Month <u>Dec.</u> Day <u>21</u> Year <u>1960</u> |  |  |  |
|--|--|--|---|--|--|--|

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|-----------------|---------------------------|--|----------------------------------|----------------------------------|--|----------------|
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>2-2-1877</u> | 9. AGE (last birthday) <u>83</u> | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR |
|-----------------|---------------------------|--|----------------------------------|----------------------------------|--|----------------|

|   |   |   |   |
|---|---|---|---|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home maker</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | 11. BIRTHPLACE (City and state or country) <u>Orange, Mo.</u> | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> |
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| 13a. FATHER'S NAME <u>Thomas Hayton</u> | 13b. MOTHER'S MAIDEN NAME <u>Mary Ellen Hayton</u> | 14. NAME OF HUSBAND OR WIFE <u>Carl K. Elerick</u> |
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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) <u>No</u> | 16. SOCIAL SECURITY NO. <u>None</u> | 17. INFORMANT Address <u>Mrs. Robert C. Miller 11311 E. 9th</u> |
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|  |            |                                  |
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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:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> |            | INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.   | DUE TO (b) |                                  |
|  | DUE TO (c) |                                  |

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| 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.<br><input type="checkbox"/> Yes <input type="checkbox"/> N- <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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|   |  |   |
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| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 \_\_\_\_\_ on the date stated above, and to the best of my knowledge, from the causes stated.

|  |                                       |                                  |
|--|---------------------------------------|----------------------------------|
| 22a. SIGNATURE (Degree or title) <u>Hugh H. Owens, Coroner</u> | 22b. ADDRESS <u>152 Union Station</u> | 22c. DATE SIGNED <u>12-23-60</u> |
|--|---------------------------------------|----------------------------------|

|  |                             |   |   |
|--|-----------------------------|---|---|
| 23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>12-24-1960</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Mound Grove</u> | 23d. LOCATION (City, town, or county) (State) <u>Independence Mo.</u> |
|--|-----------------------------|---|---|

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|---|--|---|
| 24. FUNERAL DIRECTOR ADDRESS <u>Roland R. Speake Judip. Mo.</u> | 25. DATE RECD. BY LOCAL REG. <u>12-24-60</u> | 26. REGISTRAR'S SIGNATURE <u>Janner</u> |
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS JAN 16 1961

**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 Wayne Smith

Licensed Embalmer No. 5081

P. O. Address Indep. Mo

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