

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

OF PUBLIC HEALTH AND WELFARE

REGISTRATION DISTRICT No. 149

Primary Registration District No. 1002 Registrar's No.

**6616**

**-60-048712**

STATE FILE NUMBER

FILED VS JAN 23 1961

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>															
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kansas City</u>		Length of stay in lb <u>16 yrs</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>715 W. 13</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>715 W. 13</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>												
3. NAME OF DECEASED (Type or print) First Middle Last <u>GUY WORTHINGTON GRUMBINE</u>				4. DATE OF DEATH Month Day Year <u>Dec 30 1960</u>															
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</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>Sept. 9, 1882</u>		9. AGE (last birthday) <u>78</u>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HR Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Loader</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Western Transfer</u>		11. BIRTHPLACE (City and state or country) <u>Lewistown, PA</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>											
13a. FATHER'S NAME <u>Orlando Grumbine</u>				13b. MOTHER'S MAIDEN NAME <u>Anna Bowers</u>				14. NAME OF HUSBAND OR WIFE <u>Beatrice Grumbine</u>											
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>500-07-4270-A</u>		17. INFORMANT Address <u>Leonard Stice, 3200 E. 69</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>Arteriosclerotic Heart Disease</u> 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											
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		COUNTY		STATE	
21. I attended the deceased from _____, to _____ and last saw her/him _____ 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>Hugh A. Owens, Coroner</u>						22b. ADDRESS <u>152 Union Station</u>						22c. DATE SIGNED <u>123160</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>1-3-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Maple Hill Cemetery</u>				23d. LOCATION (City, town, or county) <u>Kansas City, Kansas</u>				(State)							
24. FUNERAL DIRECTOR OR ADDRESS <u>Melody-McGilley-Eylar Funeral Home</u> <u>1800 E. Linwood, K. C., Mo.</u>						25. DATE RECD. BY LOCAL REG. <u>12-31-60</u>		26. REGISTRAR'S SIGNATURE <u>H-L Dwyer</u>											

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF HUBERT R. OWENS

Signed *Ben. K.*  
at *Ben. K.*

*Exchange for*  
*Benjamin S. K.*

**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 *James O. Kack*

Licensed Embalmer No. *45*

P. O. Address *1509*

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.