RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-60-048757

FILED VS JAN 23 1961

DED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6551 STATE FILE NUMBER

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: 73yrs
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1627 Belleview
Inside Limits: Yes XX No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Jackson
c. CITY OR TOWN Kansas City
Inside Limits: Yes XX No ☐
d. STREET ADDRESS (If outside, give location) 1627 Belleview
Reside on Farm: Yes ☐ No XX

3. NAME OF DECEASED (Type or print) First: Clyde Middle: Last: Laughrey
4. DATE OF DEATH Month Day Year: December 28, 1960
5. SEX: Male
6. COLOR OR RACE: White
7. Married XX Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 3-23-1887
9. AGE (last birthday): 73
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): Box Maker (Retired)
10b. KIND OF BUSINESS OR INDUSTRY: K. C. Box. Co.
11. BIRTHPLACE (City and state or country): Kansas City, Mo.
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: Frank Laughrey
13b. MOTHER'S MAIDEN NAME: Carrie (Unknown)
14. NAME OF HUSBAND OR WIFE: Mary Laughrey
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT Address: Mary Laughrey, 1627 Belleview, K.C. Mo.

MEDICAL CERTIFICATION

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
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 (Degree or title): Hugh H. Owens Coroner
22b. ADDRESS: 152 Union Station
22c. DATE SIGNED: 12-28-60

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 31 Dec 60
23c. NAME OF CEMETERY OR CREMATORY: Forest Hill
23d. LOCATION (City, town, or county) (State): K. C., Mo.

24. FUNERAL DIRECTOR: Mellody-McGilley-Eylar,
ADDRESS: 20 West Linwood K. C. Mo.
25. DATE RECD. BY LOCAL REG.: 12-28-60
26. REGISTRAR'S SIGNATURE: H-L-Dwyer

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF Hugh H. Owens

DOCUMENT

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_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No. 503

P. O. Address K.C.

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