

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-001420

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED **FILED VS JAN 2 1 1961** Registration District No. **149** Primary Registration District No. **1002** Registrar's No. **4**

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived if institution) Residence before admission a. STATE MO. b. COUNTY JACKSON	
b. CITY (if outside corporate limits, give TOWNSHIP only) KANSAS CITY Length of stay in 1b 12 hrs.		c. CITY OR TOWN KANSAS CITY, NORTH Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION TRINITY LUTHERAN Hosp. Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 6713 E. 49th TERR. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First William Middle ARVEL Last HAWK			4. DATE OF DEATH Month 1 Day 1 Year 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12/31/60	9. AGE (last birthday) —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) K.C. MO.	12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME William W. Hawk		13b. MOTHER'S MAIDEN NAME MELBA JUNE YOUNG BLOOD		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT William W. Hawk K.C.M., MO. Address 6713 E. 49th TERR.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) Atelectasis of Lungs - Cause Undetermined					
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 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 **Dec 31, 1960** to **Jan 1, 1961** and last saw ^{her} him alive on **Jan 1, 1961**
 Death occurred at **5:20 A** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Otto W. Theel M.D.		22b. ADDRESS 4301 - Main St. KCMo		22c. DATE SIGNED 1-2-61	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 1-2-1961	23c. NAME OF CEMETERY OR CREMATORY SOUTH POINT CEM. ORRICK, MO.		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR C.H. BLACKMAN & SON INC. ADDRESS		25. DATE RECD. BY LOCAL REG. 1-1-61	26. REGISTRAR'S SIGNATURE Ruth Long		

DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 SHOULD READ
 ITEM NO.
 TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed W.C. Rinne

Licensed Embalmer No. 4879

P. O. Address N.C. 7th

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.