

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-065440

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 550

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>CLAY</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>KANSAS CITY</b>		Length of stay in 1b <b>5 DAYS</b>	c. CITY OR TOWN <b>KANSAS CITY NORTH</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>RESEARCH HOSPITAL</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS <b>1001 EAST 21ST AVE.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>WILLIAM F. MIZE</b>			4. DATE OF DEATH Month Day Year <b>JANUARY 31 1961</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>2/19/30</b>	9. AGE (last birthday) <b>30</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CABINET MAKER</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>KANSAS CITY, MO.</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>
13a. FATHER'S NAME <b>FRED B. MIZE</b>		13b. MOTHER'S MAIDEN NAME <b>NELLIE SNOW</b>		14. NAME OF HUSBAND OR WIFE <b>MRS. MARGARET MIZE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>			17. INFORMANT Address <b>MRS. MARGARET MIZE K.C. NO. MO.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congenital Heart Disease</b>				INTERVAL BETWEEN ONSET AND DEATH <b>Since Birth</b>	
DUE TO (b) <b>Post. Surgical Death</b>				<b>6 hours</b>	
DUE TO (c) <b>Heart Failure</b>				<b>2 hours</b>	
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 <u>Jan 26<sup>th</sup> - 61</u> to <u>Jan 30<sup>th</sup> - 61</u> and last saw her alive on <u>Jan 30<sup>th</sup> - 61</u> Death occurred at <u>7<sup>45</sup></u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>Hector W. Benoit, M.D.</i>			22b. ADDRESS <u>4620 Nichols Hwy, K.C. Mo.</u>		22c. DATE SIGNED <u>Jan 31, 61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>FEB. 2, 1961</b>	23c. NAME OF CEMETERY <b>East SLOPE CEMETERY</b>	23d. LOCATION (City, town, or county) <b>PLATTE COUNTY MISSOURI</b>		
24. FUNERAL DIRECTOR <b>D.W. NEWCOMER'S SONS</b>		25. DATE RECD. BY LOCAL REG. <b>2-1-61</b>	26. REGISTRAR'S SIGNATURE <i>Ruth Long</i>		

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF  
Hector W. Benoit, M.D., Medical Certification

**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 Harold L. Catternaick

Licensed Embalmer No. 3035

P. O. Address H. Catternaick

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.