

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-005575

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 831

AMENDED

FILED VS MAR 3 1961

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		c. CITY OR TOWN KANSAS CITY	
Length of stay in 1b 50 yrs.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Elm's Nursing Home		d. STREET ADDRESS (If outside, give location) 4211 1/2 E. 9th St.	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First CLEMENT Middle BROWN Last WHITE			4. DATE OF DEATH Month FEBRUARY Day 14 , Year 1961		
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5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7-13-1889	9. AGE (last birthday) 71	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PLUMBER	10b. KIND OF BUSINESS OR INDUSTRY C.B. White Plumbing Co. Helena, Montana	11. BIRTHPLACE (City and state or country) U.S.A.	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME STANLEY STERLING WHITE	13b. MOTHER'S MAIDEN NAME EVELYN COX	14. NAME OF HUSBAND OR WIFE GLADYS WHITE
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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) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT Gladys White, 4211 1/2 E. 9th St., K.C., Mo.
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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: --IMMEDIATE CAUSE (a) Respiratory Failure		INTERVAL BETWEEN ONSET AND DEATH 30 min
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebral Metastases		2 mos
DUE TO (c) Malignant Sarcoma		3 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Chronic Bronchitis		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.)
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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 KANSAS CITY	STATE MISSOURI
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21. I attended the deceased from Jan 1 1961 to Present and last saw her/him alive on 2-13-61 Death occurred at 10:30 AM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) George K. Boyd M.D.	22b. ADDRESS 5111 Independence Ave	22c. DATE SIGNED 2-15-61
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23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 2-17, 1961	23c. NAME OF CEMETERY OR CREMATORY MT. WASHINGTON CEMETERY	23d. LOCATION (City, town, or county) KANSAS CITY 22, MISSOURI
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24. FUNERAL DIRECTOR GEO. C. CARSON & SONS, INDEPENDENCE, MO.	25. DATE RECD. BY LOCAL REG. 2-16-61	26. REGISTRAR'S SIGNATURE Ruth Long
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24. FUNERAL DIRECTOR GEO. C. CARSON & SONS, INDEPENDENCE, MO.	25. DATE RECD. BY LOCAL REG. 2-16-61	26. REGISTRAR'S SIGNATURE Ruth Long
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(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF
George K. Boyd

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 Charles J. Tyle

Licensed Embalmer No. 4534

P. O. Address Sperry 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.