

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

1404 = 61-008682

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1404 STATE FILE NUMBER

AMENDED

FILED APR 6 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		Length of stay in 1b. 3 Months	c. CITY OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Baptist Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 7300 E. Bannister Rd.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Roger Middle Alfred Last Burns			4. DATE OF DEATH Month March Day 15 Year 1961		
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 Aug. 31, 1898	9. AGE (last birthday) 62	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) State Income Tax Agent	10b. KIND OF BUSINESS OR INDUSTRY State Income Tax	11. BIRTHPLACE (City and state or country) Kansas City, Mo.	12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME Roger Thomas Burns		13b. MOTHER'S MAIDEN NAME Sarah Ellen Jones		14. NAME OF HUSBAND OR WIFE Nora Mae Burns	
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.	17. INFORMANT Address Nora Mae Burns, Kansas City, Mo.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage					INTERVAL BETWEEN ONSET AND DEATH 4 hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) Hypertensive cardiovascular disease					unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I				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>15 Mar 61</u> to <u>15 Mar 61</u> and last saw him alive on <u>15 Mar 61</u> Death occurred at <u>2 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Jack M. Davis MD			22b. ADDRESS Raytown Mo		22c. DATE SIGNED 16 Mar 61
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 3-18, 1961	23c. NAME OF CEMETERY OR CREMATORY Lee's Summit Cemetery	23d. LOCATION (City, town, or county) Lee's Summit, Missouri	(State)	
24. FUNERAL DIRECTOR Langford Funeral Home, Lee's Summit		ADDRESS	25. DATE RECD. BY LOCAL REG. 3-20-1961	26. REGISTRAR'S SIGNATURE Ruth N. Long	

DATE AMENDED

INSTEAD OF DOCUMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF Jack M. Davis, 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 *D. B. Langford*

Licensed Embalmer No. 4962

P. O. Address *Leidum*

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.