

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-008874

STATE FILE NUMBER

AMENDED

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 933

FILED VS MAR 13 1961

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>JACKSON</u>	b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>	a. STATE <u>Missouri</u>	b. COUNTY <u>JACKSON</u>
Length of stay in lb <u>59 years</u>		c. CITY OR TOWN <u>Kansas City</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St Marys Hosp. D.O.H.</u>		d. STREET ADDRESS <u>616 E 65th St</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First <u>Carl</u>	Middle <u>H</u>	Last <u>Jensen</u>	4. DATE OF DEATH	Month <u>Feb</u>	Day <u>20</u>	Year <u>1961</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>July 31, 1901</u>	9. AGE (last birthday) <u>59</u>	IF UNDER 1 YEAR Months Days	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) <u>Retail Furniture</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Furniture</u>	11. BIRTHPLACE (City and state or country) <u>Kansas City, Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Hal P. Jensen</u>	13b. MOTHER'S MAIDEN NAME <u>Ida Nigren</u>	14. NAME OF HUSBAND OR WIFE <u>Katherine Jensen</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Katherine Jensen 616 E 65th</u>
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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:	INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Shock & hemorrhage resulting from laceration of heart</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	
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
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>Offensive cut to heart</u>
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20c. TIME OF INJURY Hour m. p.m. <u>2-20-61</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. CITY, TOWN, OR LOCATION <u>Kansas City, Jackson</u>	COUNTY <u>MO</u>	STATE
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21. I attended the deceased from _____ to _____ and last saw him alive on _____.

Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22. SIGNATURE (Degree or title) <u>Ruth Long</u>	22b. ADDRESS <u>6627 Parkside Lane</u>	22c. DATE SIGNED <u>2-21-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Feb. 23, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET</u>	23d. LOCATION (City, town, or county) (State) <u>Kansas City MO.</u>
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24. FUNERAL DIRECTOR <u>Muehlebach 6800 Troost</u>	25. DATE RECD. BY LOCAL REG. <u>2-22-61</u>	26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED: 2-27-61, July 31, 1903, July 31, 1901, July 31, 1961

DOCUMENT signed by Katherine Jensen

MEDICAL CERTIFICATION Kealhofer BY AFFIDAVIT OF B5682-30 & 4617-39

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

J. T. Crowell

Licensed Embalmer No. *4904*

P. O. Address *H. C. 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.