

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-009092

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1089

STATE FILE NUMBER

AMENDED

FILED MAR 20 1961

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY JACKSON	b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY	a. STATE MISSOURI	b. COUNTY JACKSON
Length of stay in 1b 47 YEARS		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 MENORAH MEDICAL CENTER		d. STREET ADDRESS (If outside, give location) 5442 FOREST AVENUE	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First MARY	Middle ELIZABETH	Last ROE	Month FEBRUARY	Day 26	Year 1961
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2/24/87	9. AGE (last birthday) 74	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PARTNER		10b. KIND OF BUSINESS OR INDUSTRY BENDER CLEANERS	11. BIRTHPLACE (City and state or country) ST. LOUIS, MISSOURI	12. CITIZEN OF WHAT COUNTRY U. S. A.	
13a. FATHER'S NAME WILLIAM WAHLMEIER		13b. MOTHER'S MAIDEN NAME E MARQUE		14. NAME OF HUSBAND <i>or wife</i> ERNEST C. ROE	

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 MRS. LAVADA QUINN Address: 5442 FOREST AVE. KANSAS CITY, MO.
---	--------------------------------	--

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)	<i>Mesenteric Strangulation</i>	
DUPLICATE (b)	<i>Repetitive Bacteriemia</i>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUPLICATE (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 checked="" 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 _____, to _____ and last saw her/him alive on _____.
Death occurred at **10:55 P.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Geo. W. Newcomer</i>	(Degree or title) DR. MED. DEPT. CHIEF	22b. ADDRESS 6927 Rustled St. Des Moines	22c. DATE SIGNED 2-28-61
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE MAR. 1, 1961	23c. NAME OF CEMETERY OR CREMATORY FLORAL HILLS CEMETERY	23d. LOCATION (City, town, or county) (State) KANSAS CITY MISSOURI
24. FUNERAL DIRECTOR D. W. NEWCOMER'S SONS	ADDRESS 1331 BRUSH CREEK KANSAS CITY, MO	25. DATE RECD. BY LOCAL REG. 3-1-61	26. REGISTRAR'S SIGNATURE <i>Ruth Long</i>

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF
ITEM NO. SHOULD READ

DOCUMENT
MEDICAL CERTIFICATION
Affidavit of Geo. W. Newcomer

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 Marvin D. Preston

Licensed Embalmer No. 5040

P. O. Address K. 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.