SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-009257

STATE FILE NUMBER

AMENDED

1992

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1116

FILED MAR 20 1961

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City — Length of stay in 1b: 12 hrs.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Lakeside — Inside Limits Yes ☑ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY Jackson
c. CITY OR TOWN Blue Springs, Mo. — Inside Limits Yes ☐ No ☑
d. STREET ADDRESS (If outside, give location) Route 2 - Box 335-1 — Reside on Farm Yes ☐ No ☑

3. NAME OF DECEASED (Type or print) First: Lynn Middle: Marie Last: Wrinkle

4. DATE OF DEATH Month: 2 Day: 25 Year: 61

5. SEX Female

6. COLOR OR RACE White

7. Married ☐ Never Married ☑ Widowed ☐ Divorced ☐

8. DATE OF BIRTH 2-25-61

9. AGE (last birthday) — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HR: Hours 12 / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (City and state or country) Kansas City, Mo.

12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME Lewis W. Wrinkle

13b. MOTHER'S MAIDEN NAME Johnson, Ruth A

14. NAME OF HUSBAND OR WIFE —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. —

17. INFORMANT Ruth A. Wrinkle, RR2-Box 335-1 Address Blue Springs, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Abdominal & Thoracic Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 9 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Erythroblastosis Fetalis
DUE TO (c) Rh Incompatibility

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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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 ☐ NOT WHILE AT WORK ☐

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 Feb 25, 1961 to Feb 25 1961 and last saw her alive on Feb 25 1961
Death occurred at 9:30 PM Feb 25, 1961 on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE James H. Via, DO (Degree or title)

22b. ADDRESS Blue Springs, Mo

22c. DATE SIGNED 2-28-61

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

23b. DATE 3-2-61

23c. NAME OF CEMETERY OR CREMATORY Blue Springs

23d. LOCATION (City, town, or county) (State) Blue Springs Mo

24. FUNERAL DIRECTOR Mayfield ADDRESS Blue Springs

25. DATE REC'D. BY LOCAL REG. 3-2-61

26. REGISTRAR'S SIGNATURE Ruth Long

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF James H. Via

DOCUMENT

INSTEAD OF

SHOULD READ

ITEM NO.

DATE AMENDED

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_____ Signed Charles E Mayfield

Signature of Student Embalmer

Licensed Embalmer No. 4638

P. O. Address Blue Springs

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.