

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-013851

STATE FILE NUMBER

Registration District No. 147

Primary Registration District No. 1002

Registrar's No. 2008

AMENDED

FILED MAY 8 1961

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		c. CITY OR TOWN <b>Kansas City</b>	
Length of stay in 1b <b>74 yrs</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>3001 Woodland</b>		d. STREET ADDRESS (If outside, give location) <b>4133 Flora</b>	
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 <b>William</b> Middle <b>Filmore</b> Last <b>McCrory</b>			4. DATE OF DEATH Month <b>4</b> Day <b>15</b> Year <b>61</b>		
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>1-31-1887</b>	9. AGE (last birthday) <b>74</b>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____	IF UNDER 24 HR Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Interior Decorator</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Interior Decorator</b>	11. BIRTHPLACE (City and state or country) <b>Kansas City, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>Isaac McCrory</b>	13b. MOTHER'S MAIDEN NAME <b>unknown</b>	14. NAME OF HUSBAND OR WIFE <b>Vondetta McCrory</b>
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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) <b>no</b>	16. SOCIAL SECURITY NO.	17. INFORMANT <b>Dorothy Taylor 4133 Flora</b>	Address
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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) <b>Cerebral Thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>
DUE TO (b) <b>Generalized Arteriosclerosis</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). <b>Chronic Brain Syndrome</b>		
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.) <b>none</b>
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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 checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>Kansas City</b>	STATE

21. I attended the deceased from <b>7 November 60</b> to <b>April 14, 61</b> and last saw him alive on <b>15 April 61</b> Death occurred at <b>2:55 PM</b> on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <b>John H. Wells, MD</b>	22b. ADDRESS <b>3718 Prospect, K.C. Mo.</b>	22c. DATE SIGNED <b>19 April 61</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>4-21-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Blue Ridge Lawn</b>	23d. LOCATION (City, town, or county) <b>Kansas City Mo.</b>
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24. FUNERAL DIRECTOR <b>Watkins Bros. Funeral Home 18th Benton</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>4-22-61</b>	26. REGISTRAR'S SIGNATURE <b>Ruth Long</b>
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

POWERMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF **John H. Wells**

ITEM NO. SHOULD READ

**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 Bruce P. Walters

Licensed Embalmer No. 4502

P. O. Address Jim Benton

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.