

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-013985

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1955

STATE FILE NUMBER

AMENDED

FILED MAY 8 1961

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>	Length of stay in 1b <u>38 yrs.</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>Armour Memorial Home</u>		d. STREET ADDRESS (If outside, give location) <u>8100 Wornall Rd.</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Josie</u> Middle <u>May</u> Last <u>Sims</u>	4. DATE OF DEATH Month <u>April</u> Day <u>19</u> Year <u>1961</u>
--	---

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 5, 1881</u>	9. AGE (last birthday) <u>79</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HR Hours <u>  </u> Min. <u>  </u>
----------------------	-------------------------------	--	--------------------------------------	----------------------------------	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Plattsburg, Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>
--	-----------------------------------	--	---

13a. FATHER'S NAME <u>John Hall Anderson</u>	13b. MOTHER'S MAIDEN NAME <u>Virginia Amanda Creed</u>	14. NAME OF HUSBAND OR WIFE <u>James Caswell Sims</u>
--	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>unknown</u>	17. INFORMANT Address <u>K. C., Mo. Armour Home Records, 8100 Wornall</u>
---	--	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 min</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Cerebral Vascular Insufficiency</u>	<u>2 months</u>
	DUE TO (c) <u>Cerebral Arteriosclerosis</u>	<u>5 years</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Old Cerebral Infarction - Possibly Recent Infarct</u>		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 <u>  </u> a.m. <u>  </u> p.m. <u>  </u>	Month, Day, Year <u>  </u> <u>  </u> <u>  </u>
---	--

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 June 1960 to present and last saw her/him alive on 4-18-61  
Death occurred at 2 AM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>George Boyd M.D.</u>	22b. ADDRESS <u>5711 Independence Ave</u>	22c. DATE SIGNED <u>4-19-61</u>
--	---	---------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>4-22-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Perrin Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Perrin, Missouri</u>
---	--------------------------	---	---

24. FUNERAL DIRECTOR ADDRESS <u>Stine &amp; McClure, Kansas City, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>4-20-61</u>	26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>
---	---	--

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED  
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
INSTEAD OF  
DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF  
SHOULD READ  
ITEM NO.

George K. Boyd

**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 Thomas A. Kochler

Licensed Embalmer No. 4995

P. O. Address D.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.