SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-014034
STATE FILE NUMBER

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1911

FILED MAY 8 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 40 Yrs
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) General Hosp — 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 Kansas City — Inside Limits Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location) 8608 Roberts — Reside on Farm Yes ☐ No ☑

3. NAME OF DECEASED (Type or print) First William Middle M Last Todd
4. DATE OF DEATH Month 4 Day 17 Year 61
5. SEX Male
6. COLOR OR RACE White
7. Married ☐ Never Married ☐ Widowed ☑ Divorced ☐
8. DATE OF BIRTH 5-31-1880
9. AGE (last birthday) 80
IF UNDER 1 YEAR Months Days — IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired
10b. KIND OF BUSINESS OR INDUSTRY Fisherman
11. BIRTHPLACE (City and state or country) Harrisonville Mo.
12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME John Todd
13b. MOTHER'S MAIDEN NAME Rosie Akers
14. NAME OF HUSBAND OR WIFE Elizabeth Todd
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Bertrude Rosie Stead Roberts — Address

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) Unknown - Probable
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. ~~DUE TO~~ (b) Pneumonitis
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH
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 4-16-61, to 4-17-61 and last saw ~~her~~ him alive on 4-17-61
Death occurred at 8:40p p.m. on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE (Degree or title) Frank Ellis M.D.
22b. ADDRESS 2400 Cherry - City
22c. DATE SIGNED 4/17/61

BY AFFIDAVIT OF

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 4-20-61
23c. NAME OF CEMETERY OR CREMATORY Green Lawn Cem.
23d. LOCATION (City, town, or county) (State) Kansas City Mo.
24. FUNERAL DIRECTOR Sheil Funeral Home — ADDRESS K.C. Mo
25. DATE RECD. BY LOCAL REG. 4-18-61
26. REGISTRAR'S SIGNATURE Ruth Long

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED — INSTEAD OF — SHOULD READ — ITEM NO. — DOCUMENT

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 _____

Signature of Student Embalmer

Licensed Embalmer No. 4954

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.