

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

2103-61-017662  
STATE FILE NUMBER

AMENDED 2873 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2103

FILED MAY 17 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>		c. CITY OR TOWN <u>KANSAS CITY</u>	
Length of stay in 1b <u>—</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>ST. LUKE'S</u>		d. STREET ADDRESS (If outside, give location) <u>3528 WYANDOTTE</u>	
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 Middle Last <u>"B" BABY GAIL MOLESWORTH</u>			4. DATE OF DEATH Month <u>3</u> Day <u>29</u> Year <u>61</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3-29-61</u>	9. AGE (last birthday)	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u>	IF UNDER 24 HR Hours <u>—</u> Min. <u>21</u>
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) <u>KANSAS CITY, MO.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>

13a. FATHER'S NAME <u>DALE RICHARD MOLESWORTH</u>		13b. MOTHER'S MAIDEN NAME <u>CAROL ANN LEWIS</u>		14. NAME OF HUSBAND OR WIFE <u>—</u>	
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. <u>—</u>		17. INFORMANT <u>DALE R. MOLESWORTH</u> Address <u>3528 WYANDOTTE K.C. MO.</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>Shuntococcus i congenital malformation of death</u>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>—</u>			
DUE TO (c) <u>—</u>			

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 checked="" 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>		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 COUNTY STATE	

21. I attended the deceased from 3-29-61 to 3-29-61 and last saw her alive on 3-29-61  
Death occurred at 11:07 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Doctor or title) <u>Leonard A. Wall M.D.</u>		22b. ADDRESS <u>35 Wyandotte Kansas, Mo. April 27/61</u>		22c. DATE SIGNED <u>MO.</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>4/29/61</u>	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY <u>St. Luke's Hosp.</u>	23d. LOCATION (City, town, or county) (State) <u>K.C. MO.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>St. Luke's Hosp. K.C. MO.</u>		25. DATE RECD. BY LOCAL REG. <u>4-28-61</u>	26. REGISTRAR'S SIGNATURE <u>St. Luke's Hosp.</u>	

DATE AMENDED  
INSTEAD OF  
DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF  
Leonard A. Wall

515

3812

**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 \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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.