

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-017790

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2668 STATE FILE NUMBER

FILED JUN 12 1961

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Length of stay in lb 50 years	c. CITY OR TOWN RAYTOWN Kansas City
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2702 E. LINWOOD LINMONT NURSING HOME		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 3714 DENTON ROAD
3. NAME OF DECEASED (Type or print) First Middle Last MAYME PRICE SNODGRASS		4. DATE OF DEATH Month Day Year 5 26 1961	
5. SEX FEMALE	6. COLOR OR RACE CAUCASIAN	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4/17/84
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Employee		10b. KIND OF BUSINESS OR INDUSTRY Aines Dairy	9. AGE (last birthday) 77
11a. BIRTHPLACE (City and state or country) Cornishville, Ky.		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13a. FATHER'S NAME James Snodgrass		13b. MOTHER'S MAIDEN NAME Mary Frances Funk	
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) NO	
16. SOCIAL SECURITY NO. -		17. INFORMANT ADDIE MINNICK	
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>Ventricular failure</u> DUE TO (b) <u>Hypostatic pneumonia about 24 hrs</u> DUE TO (c) <u>Arteriosclerotic heart disease about 15 yrs</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Senility</u>		19. ADDRESS 3714 DENTON ROAD RAYTOWN, MISSOURI KANSAS CITY INTERVAL BETWEEN ONSET AND DEATH <u>acute</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 Month, Day, Year a.m. p.m.		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 <u>May 19-1960</u> to <u>May 26 1961</u> and last saw her alive on <u>May 25-1961</u> Death occurred at <u>11:00 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>A. B. Boyer D.D.</u>		22b. ADDRESS <u>5529 Troost K.C. Mo.</u>	
22c. DATE SIGNED <u>5/27/61</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE May 29, 1961	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	
23d. LOCATION (City, town, or county) Kansas City Missouri		23e. STATE Missouri	
24. FUNERAL DIRECTOR D.W. NEWCOMER'S SONS		25. DATE RECD. BY LOCAL REG. 5-29-61	
26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>			

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 Vern Fowler

Licensed Embalmer No. 4915

P. O. Address KC 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.