

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-021431

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 2777

STATE FILE NUMBER

FILED JUN 21 1961

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		c. CITY OR TOWN Kansas City	
Length of stay in 1b 1 Year		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph Hospital		d. STREET ADDRESS (If outside, give location) 3839 Pitman Rd.	
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 ANNIE Middle LOLO Last REED			4. DATE OF DEATH Month June Day 2 Year 1961			
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH 9-15-1886	9. AGE (last birthday) 74	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (City and state or country) New Home, Missouri		12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME William Welch		13b. MOTHER'S MAIDEN NAME Sarah Reed		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 Mrs. Ben Staponki--3839 Pitman Rd.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia		INTERVAL BETWEEN ONSET AND DEATH 5 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (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) Carcinomatosis (Colon)		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 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 COUNTY STATE

21. I attended the deceased from June 6 and last saw her alive on June 1 1961 Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE W A Gist	22b. ADDRESS 330 W 47	22c. DATE SIGNED 6/2/61

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE June 5, 1961	23c. NAME OF CEMETERY OR CREMATORY Plains Cemetery	23d. LOCATION (City, town, or county) (State) Oneonta, New York
24. FUNERAL DIRECTOR Melody-McGilley-Eylar-1800 E. Linwood		25. DATE RECD. BY LOCAL REG. 6-4-61	26. REGISTRAR'S SIGNATURE Ruth Long

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

W A GIST

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

Dr. H. H. Gist
330 21. 47th St.

601-9696 -

Mon

WA-1-7717

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

James C. Hackleman

Licensed Embalmer No. 4573

P. O. Address AC 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.