

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-021505

AMENDED

Registration District No. 149 FILED JUL 5 1961

Primary Registration District No. 1002 Registrar's No. 3068

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</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>RAY TOWN 17, Mo.</u>	
Length of stay in 1b <u>14 DAYS</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>Lakeside Osteopathic</u>		d. STREET ADDRESS (If outside, give location) <u>87th + HARRISON RD</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 <u>Stella</u> Middle <u>Marie</u> Last <u>Upky</u>			4. DATE OF DEATH Month <u>6</u> Day <u>19</u> Year <u>1961</u>			
---	--	--	---	--	--	--

5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</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>9-15-1915</u>	9. AGE (last birthday) <u>45</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <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, or if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	11. BIRTHPLACE (City and state or country) <u>Southwest City, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
--	---	---	---

13a. FATHER'S NAME <u>Loyes Gates</u>	13b. MOTHER'S MAIDEN NAME <u>Bartmess</u>	14. NAME OF HUSBAND OR WIFE <u>Homer Upky</u>
---------------------------------------	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of serv) <u>No</u>	16. SOCIAL SECURITY NO. <u> </u>	17. INFORMANT <u>Homer Upky</u> Address <u>87th Harrison Rd</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>Chronic failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>
DUE TO (b) <u>Chronic bilateral pyelonephritis</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) <u>Uremia</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 checked="" type="checkbox"/> NO <input 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
---	------------------

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 19:55 to June 18, 1961 and last saw her June 17, 1961
Death occurred at 12:15 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>M.R. Lippman, D.O.</u> (Degree & title)	22b. ADDRESS <u>9140 E. 50th St. K.C. 33, Mo.</u>	22c. DATE SIGNED <u>6/19/61</u>
---	---	---------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>6-22-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BROOKING CEM.</u>	23d. LOCATION (City, town, or county) <u>RAY TOWN</u>	(State) <u>MO.</u>
---	----------------------------	---	---	--------------------

24. FUNERAL DIRECTOR <u>Hinton Funeral Home</u>	ADDRESS <u>Raytown, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>6-19-61</u>	26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>
---	----------------------------	---	--

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

R. Lippman

0110
285

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 John R. Bidmeo
Licensed Embalmer No. 453
P. O. Address Kansas City

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.