

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

2654 - 61-021535  
STATE FILE NUMBER

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. \_\_\_\_\_

**FILED JUN 21 1961**

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <b>Jackson</b>	b. CITY (if outside corporate limits, give TOWNSHIP only) OR <b>Kansas City</b>	a. STATE <b>Missouri</b>	b. COUNTY <b>Jackson</b>
Length of stay in 1b <b>35 yrs.</b>		c. CITY OR TOWN <b>Kansas City</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>642 E. 36th. St.</b>		d. STREET ADDRESS <b>4429 Genessee</b>	(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First <b>RAYMOND</b>	Middle <b>T.</b>	Last <b>WILLETTE</b>	4. DATE OF DEATH	Month <b>May</b>	Day <b>26</b>	Year <b>1961</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>1-2-86</b>	9. AGE (last birthday) <b>75</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Executive secretary</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>K. C. Ks. Ch. of Com.</b>	11. BIRTHPLACE (City and state or country) <b>Webb City, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>WILLETTE Joseph Willette</b>	13b. MOTHER'S MAIDEN NAME <b>Florence Cash</b>	14. NAME OF HUSBAND OR WIFE <b>Cleo B. Willette</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO.	17. INFORMANT <b>Mrs. Cleo B. Willette-1001 Garfield, Ks.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b>		<b>2 1/2 hours</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Hypertension</b>	<b>10-12 yrs.</b>
	DUE TO (c) <b>Arteriosclerotic heart disease</b>	<b>15 years</b>
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 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 _____ s.m. _____ p.m. _____	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 <b>Topeka, Kansas</b>
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21. I attended the deceased from **4-27-59** to **5-26-61** and last saw her alive on **1-15-61**  
Death occurred at **5:20 p** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Morris Duncan D.O.</b>	(Degree or title)	22b. ADDRESS <b>Kansas City, Missouri</b>	22c. DATE SIGNED <b>5-27-61</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>5-27-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Cem.</b>	23d. LOCATION (City, town, or county) <b>Topeka, Kansas</b>
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24. FUNERAL DIRECTOR <b>Melldoy-McGilley-Eybar-1800 E. Linwood</b>	25. DATE RECD. BY LOCAL REG. <b>5-28-61</b>	26. REGISTRAR'S SIGNATURE <b>Ruth H. Long</b>
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DATE AMENDED  
INSTEAD OF  
DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF  
Morris Duncan

Dr. Suncan

**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 E. Hackler

Licensed Embalmer No. 4573

P. O. Address T.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.