

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-024495

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 72 Primary Registration District No. 3013 Registrar's No. 111

FILED JUL 31 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>CLAY</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>NORTH KANSAS CITY</u> Length of stay in 1b c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>D.O.A. MEMORIAL HOSP</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>CLAY</u> c. CITY OR TOWN <u>KANSAS CITY</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>2801 Russell Rd</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>EARL ALBERT VANDRUFF</u>			4. DATE OF DEATH Month Day Year <u>JULY 22 1961</u>
5. SEX <u>MALE</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>2-21-1896</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman Larabee Mills</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Stockdale, Ks.</u>	9. AGE (last birthday) IF UNDER 1 YEAR IF UNDER 24 HR <u>65</u> Months Days Hours Min.
11. BIRTHPLACE (City and state or country) <u>U.S.A</u>		12. CITIZEN OF WHAT COUNTRY	
13a. FATHER'S NAME <u>Sherman Vandruff</u>		13b. MOTHER'S MAIDEN NAME <u>Florence Osburn</u>	
13c. NAME OF HUSBAND OR WIFE <u>Thelma Vandruff</u>		17. INFORMANT Address <u>Thelma Vandruff 2801 Russell Rd</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes WWI</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>Circulatory Failure, Acute</u> DUE TO (b) <u>Coronary Arteriosclerosis</u> DUE TO (c) <u>sp</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>Myocardial Infarction, Healed</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 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 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 _____ to _____ and last saw her/him alive on _____ Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>D. J. Pate, M.D. (Coroner)</u>		22b. ADDRESS <u>North Kansas City, Mo.</u>	22c. DATE SIGNED <u>7/24/61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>7-25-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Grand View Cem</u>	23d. LOCATION (City, town, or county) (State) <u>Riley, Kansas</u>
24. FUNERAL DIRECTOR ADDRESS <u>D. W. Newcomer Sons N. K. C.</u>		25. DATE RECD. BY LOCAL REG. <u>7-24-61</u>	26. REGISTRAR'S SIGNATURE <u>Marguerite Hudgens</u>

AUG 1 1961

MAR 29 1962

**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 V. Herrick Jr.  
Licensed Embalmer No. 4848

P. O. Address Rt. 6, 17, Iowa

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.