

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-025343

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3651

AMENDED

FILED AUG 8 1961

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) Kansas City		c. CITY (If outside corporate limits, give TOWNSHIP only) Kansas City	
Length of stay in Institution 30 Days		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 370I Broadway		d. STREET ADDRESS (If outside, give location) 370I Broadway	
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 Harold Middle V. Last Maher			4. DATE OF DEATH Month July Day 20 Year 1961		
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6-9-93	9. AGE (last birthday) 68	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer (Retired)		10b. KIND OF BUSINESS OR INDUSTRY AT&SF RR	11. BIRTHPLACE (City and state or country) Devon, Kansas	12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Fred W. Maher		13b. MOTHER'S MAIDEN NAME No Data		14. NAME OF HUSBAND OR WIFE Never Married	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	17. INFORMANT Address 3730 Wyoming Eula Wolthausen (Niece) K.C., Mo.
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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: IMMEDIATE CAUSE (a) Cerebral apoplexy DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Chronic Arteriosclerosis		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 <input checked="" type="checkbox"/> a.m. <input type="checkbox"/> 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 6/13/61 to 7/18/61 and last saw him alive on 7/18/61
Death occurred at 240 m on the date stated above, and to the best of my knowledge, from the causes stated.

21a. SIGNATURE (Degree or title) William Bayne Allen		22b. ADDRESS 4620 Jc. Nichols Parkway		22c. DATE SIGNED 7/21/61
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 7-21-61	23c. NAME OF CEMETERY OR CREMATORY Centerville Cemetery	23d. LOCATION (City, town, or county) (State) Ft. Scott, Kansas	
24. FUNERAL DIRECTOR H. Simmons		ADDRESS K.C.K.	25. DATE RECD. BY LOCAL REG. 7-21-61	26. REGISTRAR'S SIGNATURE Ruth Long

DATE AMENDED
INSTEAD OF
DOCUMENT
BY AFFIDAVIT OF
WILLIAM BAYNE ALLEN
MEDICAL CERTIFICATION
ITEM NO.
SHOULD READ

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

Donnan K. James

Licensed Embalmer No. 2515

P. O. Address K.C.K.

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.