

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
 DEPARTMENT OF PUBLIC HEALTH AND WELFARE

3500 -61-025380
 STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3500

AMENDED

FILED JUL 23 1961

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>		Length of stay in 1b <u>43 yrs</u>	c. CITY OR TOWN <u>Kansas City</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>General Hosp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1654 Bellview</u>
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>PABLO</u> Middle <u>DOMINGUEZ</u> Last <u>MONTOYA</u>			4. DATE OF DEATH Month <u>7</u> Day <u>9</u> Year <u>1961</u>		
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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>1-26-1901</u>	9. AGE (last birthday) <u>60</u>	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, if retired) <u>Railroad Laborer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>R.R. Terminal</u>	11. BIRTHPLACE (City and state or country) <u>Jacatecas, Mexico</u>	12. CITIZEN OF WHAT COUNTRY <u>Mexico</u>
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13a. FATHER'S NAME <u>John Montoya</u>	13b. MOTHER'S MAIDEN NAME <u>Cecilia Dominguez</u>	14. NAME OF HUSBAND OR WIFE <u>Ruey Montoya</u>
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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) <u>no</u>	17. INFORMANT <u>Ruey Montoya</u> Address <u>1654 Bellview, J.C., Mo</u>
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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) <u>Fractured skull</u>	DUE TO (b) _____	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (c) _____	

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
<u>History of Infection</u>	

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>Struck by Burlington</u>
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. <u>7-9 61</u>	<u>engine</u>
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20d. INJURY OCCURRED WHILE AT WORK <input checked="" 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.) <u>R.R. tracks</u>	20f. CITY, TOWN, OR LOCATION <u>Kansas City</u>	COUNTY <u>Jackson</u>	STATE <u>MO</u>
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21. I attended the deceased from _____ to _____ and last saw him alive on _____
 Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Hugh H. Owens</u> (Degree or title)	22b. ADDRESS <u>Coronal 152 Union Station</u>	22c. DATE SIGNED <u>7-10-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>7-14-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mound Spring Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Kansas City, Missouri</u>
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24. FUNERAL DIRECTOR <u>Heilert Funeral Homes (or) J.C., Mo.</u>	25. DATE RECEIVED BY LOCAL REG. <u>7-13-61</u>	26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 Hugh H. Owens
 BY AFFIDAVIT OF
 ITEM NO. SHOULD READ

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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

Signature *J. C. [unclear]*

Licensed Embalmer No. 4554

P. O. Address KC 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.