

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

3579-61-025525
STATE FILE NUMBER

AMENDED

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

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 b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in lb 18 Yrs	c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 11506 So 71 Hiway		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 11506 So 71 Hiway Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First MAGDALINE Middle MARY Last TAYLOR			4. DATE OF DEATH Month July Day 16 Year 1961		
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5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10/16/1886	9. AGE (last birthday) 74	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) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Osakis Minn.	11. BIRTHPLACE (City and state or country) USA	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME No Record	13b. MOTHER'S MAIDEN NAME No Record	14. NAME OF HUSBAND OR WIFE Ray Taylor
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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) No	16. SOCIAL SECURITY NO.	17. INFORMANT Kenneth L Taylor 7502 E 112th K C Mo Address
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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) Acute myocardial infarction DUE TO (b) A.C.V.D. DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH Unknown
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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
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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.)
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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 _____
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21. I attended the deceased from July 16, 1961 to July 16, 1961 and last saw her alive on 1961-7-16
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Herbert L. Ketterman M.D. (Degree or title)	22b. ADDRESS Shickmanville, Mo	22c. DATE SIGNED 7/17/61
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE July 19 1961	23c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery	23d. LOCATION (City, town, or county) Kansas City Missouri
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24. FUNERAL DIRECTOR Shell Colonial Chapel Lansas City ADDRESS	25. DATE RECD. BY LOCAL REG. 7-18-61	26. REGISTRAR'S SIGNATURE Ruth Long
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF
Herbert L. Ketterman
MEDICAL CERTIFICATION

Dr KETTERMAN

112 + 71 Highway

DECEASED

RESIDENT

DECEASED

X

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

NAME OF DECEASED

ADDRESS OF DECEASED

SEX

AGE

HEIGHT

WEIGHT

HAIR

EYES

COMPLEXION

SCARS

HAIR

SCARS

SCARS

DATE OF DEATH

BY

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 Thomas A. Smith

Licensed Embalmer No. 4954

P. O. Address K. C. M.

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.

DATE OF DEATH

TIME OF DEATH