

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

3910-61-029354
3910 STATE FILE NUMBER

AMENDED

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

FILED AUG 25 1961

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

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) OR TOWN KANSAS CITY		Length of stay in 1b 3 WEEKS		c. CITY OR TOWN RAYTOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LUKE'S HOSPITAL			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 5552 BLUE RIDGE BLVD.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last WALTER V. HUSTON				4. DATE OF DEATH Month Day Year AUGUST 6 1961						
5. SEX MALE		6. COLOR OR RACE WHITE		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 1/19/04		9. AGE (last birthday) 57		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ATTORNEY		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) GENEVA, NEBRASKA		12. CITIZEN OF WHAT COUNTRY U. S. A.				
13a. FATHER'S NAME WALTER HUSTON			13b. MOTHER'S MAIDEN NAME IDA UNKNOWN			14. NAME OF HUSBAND OR WIFE MRS. GENEVIEVE HUSTON				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				17. INFORMANT GENEVIEVE HUSTON					Address 5552 BLUE RIDGE RAYTOWN, MO. BLVD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure (c) Carcinoma - Bronchiogenic (b) Cerebral Metastases Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (a) Respiratory Failure DUE TO (c) Carcinoma - Bronchiogenic DUE TO (b) Cerebral Metastases								INTERVAL BETWEEN ONSET AND DEATH 107min 6 months 1 month		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease/condition given in PART I (e) Widespread Metastases, Hepatic + Renal Failure						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 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		COUNTY		STATE		
21. I attended the deceased from June 1961 to Present and last saw her alive on 8-5-61 Death occurred at 2:30 A. m on the date stated above, and to the best of my knowledge, from the causes stated.										
22a. SIGNATURE (Degree or title) George K Boyd MD				22b. ADDRESS 5111 Independence Ave KCMo				22c. DATE SIGNED 8-7-61		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE AUG. 8, 1961		23c. NAME OF CEMETERY OR CREMATORY FLORAL HILLS CEMETERY		23d. LOCATION (City, town, or county) KANSAS CITY		23e. (State) MISSOURI		
24. FUNERAL DIRECTOR D. W. NEWCOMER'S SONS				ADDRESS 1351 BRUSH CR. KANSAS CITY, MO.		25. DATE RECD. BY LOCAL REG. 8-7-61		26. REGISTRAR'S SIGNATURE Ruth Long		

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 Vern Lawler

Licensed Embalmer No. 4915

P. O. Address RG 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.