

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

4189-61-029573
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1.002 Registrar's No. 4189

AMENDED

FILED AUG 31 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>K.C.</u>		c. CITY OR TOWN <u>Kansas City</u>	
Length of stay in 1b <u>1 hr 55 min</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>407 No. Denver</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Infant Price</u>			4. DATE OF DEATH Month Day Year <u>August 20 1961</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8-30-61</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) IF UNDER 1 YEAR IF UNDER 24 HR Months - Days - Hours - Min. <u>1 hr 55 min</u>
11. BIRTHPLACE (City and state or country) <u>K.C., Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Robert Wynn Price</u>		13b. MOTHER'S MAIDEN NAME <u>Joye Yvonne Watson</u>	
14. NAME OF HUSBAND OR WIFE <u>-</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, (no) or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Joye Yvonne Price</u> Address <u>407 No. Denver</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>Respiratory failure</u> DUE TO (b) <u>Premature delivery</u> DUE TO (c) <u>-</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>1 hr - 55 min</u> <u>1 hr - 55 min</u>
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 checked="" 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 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 <u>8/20/61</u> to <u>8/20/61</u> and last saw her <u>alive</u> on <u>8/20/61</u> Death occurred at <u>St. Joseph Hosp. 5³⁰</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>T. E. Van Buskirk M.D.</u>		22b. ADDRESS <u>5246 St. John K.C. Mo</u>	22c. DATE SIGNED <u>8/20/61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE <u>8/22/1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Elmwood Crematory</u>	23d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo</u>
24. FUNERAL DIRECTOR <u>T.C. Blackman & Son 14. C. Mo 8-22-61</u>		25. DATE RECD. BY LOCAL REG. <u>8-22-61</u>	
26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>			

DATE AMENDED

INSTEAD OF THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

Van Buskirk

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 W.C. Devine

Licensed Embalmer No. 4879

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.