

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

4125-61-029745
STATE FILE NUMBER

AMENDED

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

FILED AUG 31 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) OR TOWN Kansas City			Length of stay in lb 10 days		c. CITY OR TOWN Hickman Mills		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. Lukes Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 8721 Craig Rd		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First John Middle Leo Last Young				4. DATE OF DEATH Month 8 Day 17 Year 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 2 17 94	9. AGE (last birthday) 67	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Land Scaper		10b. KIND OF BUSINESS OR INDUSTRY Gardner		11. BIRTHPLACE (City and state or country) Lone Jack, Missouri		12. CITIZEN OF WHAT COUNTRY U. S. A	
13a. FATHER'S NAME John Young			13b. MOTHER'S MAIDEN NAME Fannie Moutrey		14. NAME OF HUSBAND OR WIFE Essie P Young		
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 Mrs. Essie P. Young 8721 Craig Rd			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremic Coma Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Chr. Cardiac Decompenstation DUE TO (c) Rheumatoid and A.I.S. Art Disease.						INTERVAL BETWEEN ONSET AND DEATH 2 Mo. 10 Mo. 10+ Yr.	
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	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> none			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) ---			
20c. TIME OF INJURY Hour --- Month, Day, Year --- a.m. --- p.m. ---	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 1945 to 8/17/61 and last saw him alive on 8/16/61 Death occurred at 3:15 a.m. m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Robert J. Boody M.D.				22b. ADDRESS 217 Rega Zino Bldg Ke		22c. DATE SIGNED 8/18/61	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 8 19 61	23c. NAME OF CEMETERY OR CREMATORY Kansas City Hills		23d. LOCATION (City, town, county) Kansas City Missouri		(State)
24. FUNERAL DIRECTOR Floral Hills Memorial Chapels, Inc			ADDRESS C. Mo		25. DATE RECD. BY LOCAL REG. 8-18-61	26. REGISTRAR'S SIGNATURE Ruth Long	

DATE AMENDED

INSTEAD OF THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF
Robert J. Boody

by James Bailey

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 *E. M. Jovine*

Licensed Embalmer No. 3453

P. O. Address *H. E. Kane*

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.