

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-032742

STATE FILE NUMBER

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4620

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 1b 26 Yrs.	c. CITY OR TOWN Kansas City
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Research Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 3929 Bell
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First MOSSELEIN Middle Last BLACK	4. DATE OF DEATH Month September Day 16 Year 1961
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5. SEX Female	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 1-21-89	9. AGE (last birthday) 72	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) At Home	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Bloomington, Ill.	12. CITIZEN OF WHAT COUNTRY U. S. A.
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13a. FATHER'S NAME Charles G. Gibson	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE William W. Black
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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. None	17. INFORMANT Address William W. Black, Jr. K. C. Mo.
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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) <u>pulmonary embolism</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
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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) <u>Fractures pubis base</u>	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
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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 11-20-56 to 9-16-61 and last saw her alive on 9-15-61
Death occurred at 2:35 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Dr. Clayton M Day M.D. or Martin J. Mueller M.D.</u>	22b. ADDRESS <u>535 Angye Blvd KCMO</u>	22c. DATE SIGNED <u>9-16-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9-18-1961	23c. NAME OF CEMETERY OR CREMATORY Mt. Washington	23d. LOCATION (City, town, or county) (State) Kansas City, Mo.
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24. FUNERAL DIRECTOR Freeman Mortuary	ADDRESS Kansas City, Mo.	25. DATE RECD. BY LOCAL REG. 9-16-61	26. REGISTRARS SIGNATURE <u>Ruth Long</u>
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED
INSTEAD OF
DOCUMENT
BY AFFIDAVIT OF
ITEM NO. SHOULD READ
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

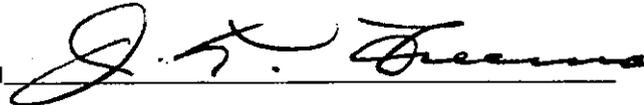
Ira C. Layton By Medical Certification

M. MUELLER
535 ARGYLE BLDG.

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  _____

Licensed Embalmer No. 2939
P. O. Address F. 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.