

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-032890

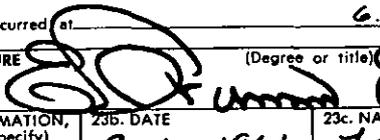
DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4433

FILED SEP 20 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>CLAY</u>											
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Length of stay in 1b <u>35 YRS.</u>		c. CITY OR TOWN <u>KANSAS CITY</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>General Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>4613 WINN Rd</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>W</u> Last <u>Hector</u>				4. DATE OF DEATH Month <u>SEPT</u> Day <u>4</u> Year <u>1961</u>											
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>3-10-1927</u>		9. AGE (last birthday) <u>33</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (City and state or country) <u>Gower, Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>					
13a. FATHER'S NAME <u>JAMES HECTOR</u>				13b. MOTHER'S MAIDEN NAME <u>Hannah</u>				14. NAME OF HUSBAND OR WIFE <u>Melissa Hector</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>MRS. Melissa Porter</u>		Address <u>4613 Winn Rd</u> <u>K.S. 16 Mo</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										INTERVAL BETWEEN ONSET AND DEATH					
IMMEDIATE CAUSE (a) <u>cerebral thrombosis</u>															
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.															
DUE TO (b) <u>hemorrhagic pneumonia</u>															
DUE TO (c)															
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 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>8-29-61</u> to <u>9-4-61</u> and last saw ^{him} him alive on <u>9-4-61</u> Death occurred at <u>6:05 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.															
22a. SIGNATURE 				(Degree or title)				22b. ADDRESS <u>2400 Cherry</u>				22c. DATE SIGNED <u>9-5-61</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>9-6-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fairview cemetery</u>				23d. LOCATION (City, town, or county) <u>Liberty, Mo.</u>				(State)			
24. FUNERAL DIRECTOR <u>D. W. Neulomier</u>				ADDRESS <u>Low N.R.C.</u>				25. DATE RECD. BY LOCAL REG. <u>9-6-61</u>		25. REGISTRAR'S SIGNATURE <u>Ruth Long</u>					

(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF
 Frank Ellis

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 Shawn H. Hill

Licensed Embalmer No. 4586

P. O. Address K. C. 18, 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.