

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-033019

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4437

STATE FILE NUMBER

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>MISSOURI</u> b. COUNTY <u>JACKSON</u>		
b. CITY (If outside corporate limits, give township only) <u>Kansas City</u> OR TOWN <u>1230 OAKLEY</u>		Length of stay in 1b <u>40 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>TRINITY LUTHERN HOSPITAL</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1230 OAKLEY</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>COILY</u> Last <u>MILLS</u>			4. DATE OF DEATH Month <u>9</u> - Day <u>5</u> - Year <u>61</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>7-29-10</u>	9. AGE (last birthday) <u>51</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRACTICAL NURSE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	11. BIRTHPLACE (City and state or country) <u>CARROLLTON MO.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>ORE T. LOFFER</u>		13b. MOTHER'S MAIDEN NAME <u>MARY VAUGHN</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) <u>NO.</u>		16. SOCIAL SECURITY NO. <u> </u>	17. INFORMANT Address <u>WILLIAM T. MILLS 2221 DENVER K.C. MO.</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>Pneumonia - Bronchial</u>					INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Ca of lung -</u>					<u>2-3 yrs?</u>
DUE TO (c) <u>?</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Possible metastases to Brain</u>				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 <u> </u> a.m. <u> </u> p.m.	Month, Day, Year				
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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>21 June 61</u> to <u>5 Sept 61</u> and last saw her alive on <u>5 Sept 61</u> Death occurred at <u> </u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Robert M. Myers M.D.</u>			22b. ADDRESS <u>906 Grand Ave K.C. 68461</u>		22c. DATE SIGNED <u> </u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>9-8-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>FOREST HILL</u>		23d. LOCATION (City, town, or county) (State) <u>KANSAS CITY MISSOURI</u>	
24. FUNERAL DIRECTOR <u>SHEIL FUNERAL HOME K.C. MO.</u>		ADDRESS	25. DATE RECD. BY LOCAL REG. <u>9-6-61</u>	26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>	

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF
Robert M. Myers

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 Thomas A. Shiel

Licensed Embalmer No. 4854

P. O. Address: S. C. 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.