

MISSOURI DIVISION OF PUBLIC HEALTH - STANDARD CERTIFICATE OF DEATH

-61-033061

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4575 STATE FILE NUMBER

AMENDED  
 DATE AMENDED  
 INSTEAD OF  
 DOCUMENT  
 AMENDMENTS ON THIS RECORD ARE TO BE MADE  
 BY AFFIDAVIT OF  
 James E. Griffin, M.D. CERTIFICATION  
 ITEM NO. SHOULD READ

FILED SEP 25 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>Kansas City</u>		c. CITY OR TOWN <u>Kansas City</u>	
Length of stay in lb <u>7 hr 12 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>Lakeside Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>216 E. 34th Tenac</u>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>PATRICIA</u> Middle <u>FRYE</u> Last <u>POWELL</u>			4. DATE OF DEATH Month <u>9</u> Day <u>12</u> Year <u>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>9-12-61</u>	9. AGE (last birthday)	IF UNDER 1 YEAR Months <u>7</u> Days <u>12</u>	IF UNDER 24 HR Hours <u>12</u> Min. <u></u>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Kansas City, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Wesley Thomas Powell</u>			13b. MOTHER'S MAIDEN NAME <u>Virginia Patricia Steeter</u>			14. NAME OF HUSBAND OR WIFE <u>none</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>Wesley P. Powell Jr, M.D. Mo</u>		Address <u>216 E. 34th Tenac</u>	
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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:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>atalectases</u>			
DUE TO (b) <u>Prematurity</u>			
DUE TO (c) <u>Premature placental separation</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 type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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> Month, Day, Year <u></u> a.m. <u></u> p.m. <u></u>							

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>9-12-61</u> to <u>9-12-61</u> and last saw her alive on <u>9-12-61</u> Death occurred at <u>11:15 AM</u> m on the date stated above, and to the best of my knowledge, from the causes stated.									

22a. SIGNATURE (Degree or title) <u>James E. Griffin, M.D.</u>			22b. ADDRESS <u>3900 Paseo KCMO</u>			22c. DATE SIGNED <u>9/13/61</u>		
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>9-14-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Forest Hill</u>		23d. LOCATION (City, town, or county) (State) <u>Kansas City Mo</u>		
Funeral Director <u>Melody McElroy - Sylva - E. Linwood</u>				25. DATE RECD. BY LOCAL REG. <u>9-13-61</u>		26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>		

J. E. Duff  
3700 Ave  
No 1-46

**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 Hal Hombough

Licensed Embalmer No. 3408

P. O. Address Indep.

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.