

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

FILED 007 4 1961

Primary Registration District No. 1002 Registrar's No.

4618-61-033115 STATE FILE NUMBER

AMENDED

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)				
a. COUNTY Jackson		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b Life		c. CITY OR TOWN Kansas City		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4806 E 31st St		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 4806 E 31st St		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH				
First ELIZABETH		Middle M		Last SHOTTS		Month September Day 15 Year 1961		
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 9/7/13		
9. AGE (last birthday) 47		IF UNDER 1 YEAR		IF UNDER 24 HR		Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY Mail Handler		11. BIRTHPLACE (City and state or country) Kansas City Mo		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME UNK			13b. MOTHER'S MAIDEN NAME Althea UNK			14. NAME OF HUSBAND OR WIFE Walter Shotts		
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.		17. INFORMANT Walter Shotts 4806 E 31st St		
18. CAUSE OF DEATH (Enter only one cause by for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Myocardial failure							1 mo	
DUE TO (b) atherosclerosis							—	
DUE TO (c)							—	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.								
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 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 7/21/61 to Sept 15-61 and last saw her alive on Sept 12-61				Death occurred at 230 P m on the date stated above, and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE (Degree or title) H. C. Tripp				22b. ADDRESS 6247 Brookside Dr		22c. DATE SIGNED 9/15/61		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9-18-61		23c. NAME OF CEMETERY OR CREMATORY Mt Washington Cem		23d. LOCATION (City, town, or county) Independence Missouri		
24. FUNERAL DIRECTOR Sheil Funeral Home K C Mo				25. DATE RECD. BY LOCAL REG. 9-15-61		26. REGISTRAR'S SIGNATURE Ruth Long		

DATE AMENDED

INSTEAD OF DOCUMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

BY AFFIDAVIT OF **H. C. Tripp** MEDICAL CERTIFICATION

NAME OF DECEASED _____

DATE OF DEATH _____

PLACE OF DEATH _____

DECEASED WAS _____
BY _____

AT _____

ON _____

AT _____

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. [Signature]*

Licensed Embalmer No. 4954

P. O. Address K.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.

IT IS HEREBY CERTIFIED THAT THE ABOVE IS TRUE AND CORRECT.

OFFICE OF THE STATE EMBALMER