

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-033208

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4751

STATE FILE NUMBER

AMENDED

FILED OCT 11 1961

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <b>Jackson</b>	b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>	a. STATE <b>Missouri</b>	b. COUNTY <b>Jackson</b>
Length of stay in 1b <b>1 day 16 hrs.</b>		c. CITY <b>Kansas City</b>	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Baptist Memorial Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>7205 E. 108th. St. Dr.</b>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	4. DATE OF DEATH
First Middle Last <b>Sherry Lynne Wray</b>	Month Day Year <b>9-21 1961</b>

5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>9-19-61</b>	9. AGE (last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HR
			Months	Days	Hours	Min.
				<b>1</b>	<b>16</b>	<b>9</b>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>infant</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Kansas City, Missouri</b>	12. CITIZEN OF WHAT COUNTRY <b>U. S.</b>
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13a. FATHER'S NAME <b>Ivan G. Wray</b>	13b. MOTHER'S MAIDEN NAME <b>Mary E. Carroll</b>	14. NAME OF HUSBAND OR WIFE <b>none</b>
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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) <b>no</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT <b>Mr. Ivan G. Wray</b>	Address <b>7205 E. 108th. St. Dr.</b>
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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) <b>atelectasis</b>	<b>40 hrs.</b>
Conditions, if any, which gave rise to above cause (a) stating the underlying cause last.	<b>40 hrs.</b>
DUE TO (b) <b>prematurity</b>	<b>40 hrs.</b>
DUE TO (c) <b>caesarian section</b>	<b>40 hrs.</b>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>erythroblastosis fetalis</b>	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
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19. WAS AUTOPSY PERFORMED? YES <input checked="" 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.)
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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 <b>9-19-61</b> to <b>9-21-61</b>	COUNTY <b>9-20-61</b>	STATE
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21. I attended the deceased from <b>1:45A.</b> to <b>9-20-61</b> and last saw her/him alive on <b>9-20-61</b> Death occurred at <b>1:45A.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <b>Roy F. Garrison, M.D.</b>	22b. ADDRESS <b>6509 Prospect</b>	22c. DATE SIGNED <b>9-23-61</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>9-23-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Forest Hill</b>	23d. LOCATION (City, town, or county) (State) <b>Kansas City, Mo.</b>
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24. FUNERAL DIRECTOR <b>Weilert Funeral Home</b>	ADDRESS <b>K. C. Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>9-23-61</b>	26. REGISTRAR'S SIGNATURE <b>Ruth Long</b>
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 BY AFFIDAVIT OF  
 DATE AMENDED  
 ITEM NO. SHOULD READ

**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. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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.