

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

4912-61-036943

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1.002 Registrar's No. 4942

FILED OCT 19 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

AMENDED

|  |  |  |   |
|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Jackson</u>  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u> |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>                 |  | Length of stay in 1b <u>2 days + 15 min</u>  | c. CITY OR TOWN <u>Kansas City</u>                                |
| 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>406 West 7th</u> |
| 3. NAME OF DECEASED (Type or print) First <u>ROBERT</u> Middle <u>WILLIAM</u> Last <u>HARRIS JR.</u> |  | 4. DATE OF DEATH Month <u>10</u> Day <u>3</u> Year <u>61</u>   |   |

|                    |                               |  |                                 |   |
|--------------------|-------------------------------|--|---------------------------------|---|
| 5. SEX <u>male</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>10-1-61</u> | 9. AGE (last birthday) IF UNDER 1 YEAR Months <u>3</u> Days <u>2</u> Hours <u>15</u> IF UNDER 24 HR Min <u>15</u> |
|--------------------|-------------------------------|--|---------------------------------|---|

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| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u> | 11. BIRTHPLACE (City and state or country) <u>Kansas City, Missouri, U.S.A.</u> | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> |
|--|---|---|

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|---|--|--|
| 13a. FATHER'S NAME <u>Robert William Harris Sr.</u> | 13b. MOTHER'S MAIDEN NAME <u>Sharon Leona Thornburgh</u> | 13c. NAME OF HUSBAND OR WIFE <u>None</u> |
|---|--|--|

|  |                                     |   |
|--|-------------------------------------|---|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u> | 16. SOCIAL SECURITY NO. <u>None</u> | 17. INFORMANT <u>Mr. Robert William Harris Sr. 406 West 7th St. E., Mo.</u> |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Prematurity</u> |  | INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____                  |  |                                  |

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| 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.<br><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 _____ |
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|  |  |   |
|--|--|---|
| 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 10-1-61 to 10-3-61 and last saw <sup>him</sup> her alive on 10-3-61  
Death occurred at 9:30 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

|   |   |                                 |
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| 22a. SIGNATURE <u>[Signature]</u> (Degree or title) | 22b. ADDRESS <u>2400 Cherry St. Mo.</u> | 22c. DATE SIGNED <u>10-4-61</u> |
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|   |                          |  |  |
|---|--------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE <u>10-6-61</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Forest Hill Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>Kansas City, Missouri</u> |
|---|--------------------------|--|--|

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|---|---|--|
| 24. FUNERAL DIRECTOR <u>Wilbert Funeral Homes</u> ADDRESS <u>St. Louis, Mo.</u> | 25. DATE RECD. BY LOCAL REG. <u>10-5-61</u> | 26. REGISTRAR'S SIGNATURE <u>Ruth Long</u> |
|---|---|--|

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

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

*B. E. Weichert*

Licensed Embalmer No.

*4075*

P. O. Address

*3128 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.