

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

5014-61-037012
STATE FILE NUMBER

AMENDED

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

FILED OCT 19 1961

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 23 years	c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Norwood Nursing Home		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1640 Spruce Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Lewis Middle Burriss Last Kershner			4. DATE OF DEATH Month October Day 8 Year 1961		
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5. SEX male	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10/23/1887	9. AGE (last birthday) 73	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Orderly	10b. KIND OF BUSINESS OR INDUSTRY Bethany Hospital	11. BIRTHPLACE (City and state or country) Paola, Kansas	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME Owen Elmer Kershner	13b. MOTHER'S MAIDEN NAME Alice M. McCain	14. NAME OF HUSBAND OR WIFE Never married
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give way or dates of service) yes W. W. #1	16. SOCIAL SECURITY NO.	17. INFORMANT Elmer C. Kershner 1640 Spruce K.C., Mo.
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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 Seasonal
IMMEDIATE CAUSE (a)	Hypostatic Pneumonia	
DUE TO (b)	Cardiac decompensation & failure.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (c)	Altered reflexes.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). Parkinson disease senility		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 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.)
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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
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21. I attended the deceased from **2-2-60** to **10-8-61** and last saw ^{her} alive on **10-3-61**
Death occurred at **3:15 Am** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) M. Haight MD	22b. ADDRESS 3401 E 12th KC Mo	22c. DATE SIGNED 10-9-61
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23a. BURIAL (CREMATION, REMOVAL (Specify) Removal	23b. DATE Oct. 10, 1961	23c. NAME OF CEMETERY OR CREMATORY Stanton Cemetery	23d. LOCATION (City, town, or county) (State) Paola, Kansas
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24. FUNERAL DIRECTOR Earp & Sons 4707 Truman Rd. K.C., Mo.	25. DATE RECD. BY LOCAL REG. 10-9-61	26. REGISTRAR'S SIGNATURE Ruth Long
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DATE AMENDED

INSTEAD OF DOCUMENTS ON THIS RECORD ARE AS FOLLOWS

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF M. Haight

BY AFFIDAVIT OF

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

James W. Earp

Licensed Embalmer No. 4622

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.