

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-037033

Registration District No. 149 Primary Registration District No. 1602 Registrar's No. 4973 STATE FILE NUMBER

DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

FILED OCT 19 1961

1. PLACE OF DEATH
 a. COUNTY Jackson
 b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City Length of stay in lb 65 yrs
 c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4235 Scarritt Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
 a. STATE Mo b. COUNTY Jackson
 c. CITY OR TOWN Kansas City Inside Limits Yes No
 d. STREET ADDRESS (If outside, give location) 4235 Scarritt Reside on Farm Yes No

3. NAME OF DECEASED First Middle Last 4. DATE OF DEATH Month Day Year
ADA FRANCES LEE 10 5 1961

5. SEX Female 6. COLOR OR RACE White 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH 3/1/1890 9. AGE (last birthday) 71
 IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY at Home 11. BIRTHPLACE (City and state or country) Buffalo, Mo 12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME James Wollard 13b. MOTHER'S MAIDEN NAME Sarah Miller 13c. NAME OF HUSBAND OR WIFE John W. Lee

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO. none 17. INFORMANT John W. Lee Address R.C., Mo. 4235 Scarritt

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) Angina Pectoris
 DUE TO (b) Hypertension & 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) Obesity
 PART III. If deceased was female was there a pregnancy in last 90 days. Yes No Unknown
 INTERVAL BETWEEN ONSET AND DEATH and year 4 + year

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) _____

20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____

20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 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 April 1958 to 10-5-61 and last saw her alive on April 18 1961
 Death occurred at 7:30 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) James B. Leitz MD 22b. ADDRESS 1530 W. Bluffton, Mo 22c. DATE SIGNED 10-6-61

23. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE 10/7/1961 23c. NAME OF CEMETERY OR CREMATORY Mt. Moriah 23d. LOCATION (City, town, or county) (State) Kansas City, Mo

24. FUNERAL DIRECTOR C.H. Blackman ADDRESS R.C., Mo 25. DATE RECD. BY LOCAL REG. 10-6-61 26. REGISTRAR'S SIGNATURE Ruth Long

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 W.C. Penne

Licensed Embalmer No. 4879

P. O. Address A.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.