ISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

RTMENT OF PUBLIC HEALTH AND WELFARE

-61-037089
STATE FILE NUMBER

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5020

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 1b: 72 YRS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3225½ EAST 10TH — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MISSOURI COUNTY JACKSON
c. CITY OR TOWN KANSAS CITY — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 3225½ EAST 10TH — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First NORA Middle ELLA Last MIDDAUGH
4. DATE OF DEATH: Month OCT. Day 8, Year 1961
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 11-18-1877
9. AGE (last birthday): 83
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): ---
10b. KIND OF BUSINESS OR INDUSTRY: ---
11. BIRTHPLACE (City and state or country): CLEVELAND, OHIO
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: LOREN G; MIDDAUGH
13b. MOTHER'S MAIDEN NAME: ELIZABETH FITZSIMMONS
14. NAME OF HUSBAND OR WIFE: ---
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service): ---
16. SOCIAL SECURITY NO.: ---
17. INFORMANT: MRS; ELIZABETH FRICKE Address 2829 E. 6TH K.C.MO

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Viral Influenza — INTERVAL BETWEEN ONSET AND DEATH: 3 days.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Arteriosclerotic Heart Disease
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

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 a.m. p.m. Month, Day, Year
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 9-29-59, to Oct 8, 61 and last saw her/him alive on Oct 7, 61
Death occurred at ___ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Robert L. Ward, M.D. (Degree or Title)
22b. ADDRESS 4126 St John
22c. DATE SIGNED 10-9-61

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: OCT; 10, 1961
23c. NAME OF CEMETERY OR CREMATORY: MT; WASHINGTON
23d. LOCATION (City, town, or county) (State): KANSAS CITY, MISSOURI

24. FUNERAL DIRECTOR: C.H. BLACKMAN & SON INC. ADDRESS
25. DATE RECD. BY LOCAL REG.: 10-9-61
26. REGISTRAR'S SIGNATURE: Ruth Long

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO.

BY AFFIDAVIT OF DOCUMENT

MEDICAL CERTIFICATION Robert L. Ward

Robt. Ward
Hu 3 3119
After 1 P.M.

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 Hubert B. Baird

Licensed Embalmer No. 4888

P. O. Address NC 24, 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.