

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-037212

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

5365 STATE FILE NUMBER

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

FILED NOV 13 1961

AMENDED

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF
George K. Boyd

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		c. CITY OR TOWN INDEPENDENCE	
Length of stay in lb 10 days		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. JOSEPH HOSP.		d. STREET ADDRESS 2327 HARRIS	
3. NAME OF DECEASED (Type or print) First MYRTLE Middle ELLEN Last SMITH		4. DATE OF DEATH Month OCTOBER Day 27 Year 1961	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2-1-1885
9. AGE (last birthday) 76		IF UNDER 1 YEAR IF UNDER 24 HR Months Days 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 DOMESTIC	
11. BIRTHPLACE (City and state or country) PULASKI, ILLINOIS		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME JAMES ANDREW CALVIN		13b. MOTHER'S MAIDEN NAME ANNIE EASTWOOD	
14. NAME OF HUSBAND OR WIFE JAMES MOSES SMITH-dec'd.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT James I. Smith, 2327 Harris, Indep., Mo.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure			INTERVAL BETWEEN ONSET AND DEATH 3 weeks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. aggravated by: Rheumatic + Arteriosclerotic Heart Disease			10 years
DUE TO (b) Severe anemia			3 months
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Carcinoma of Cecum - chronic bleeding			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
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.)	
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	COUNTY STATE
21. I attended the deceased from Oct 16 1961 to present and last saw her alive on 10-27-61 Death occurred at 6:35 Am m of the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) George K. Boyd M.D.		22b. ADDRESS 5111 Independence Ave	22c. DATE SIGNED 10/27/61
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 10-30-61	23c. NAME OF CEMETERY OR CREMATORY MT. WASHINGTON CEMETERY	23d. LOCATION (City, town, or county) INDEPENDENCE, MO.
24. FUNERAL DIRECTOR GEO. C. CARSON & SONS, INDEPENDENCE, MO.		25. DATE RECD. BY LOCAL REG. 10-27-61	26. REGISTRAR'S SIGNATURE Ruth Long

For: *Max Royal*

5111 Ludlow Ave.

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.