

# SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-037227

MENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4902

STATE FILE NUMBER

**FILED OCT 19 1961**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Jackson</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		c. CITY OR TOWN <b>Kansas City</b>	
Length of stay in 1b <b>5 Years</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Heartstone Nursing Home</b>		d. STREET ADDRESS (If outside, give location) <b>2000 Washington Street</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

<b>3. NAME OF DECEASED</b> (Type or print) First <b>K A T E</b> Middle <b>S T E W A R T</b> Last			<b>4. DATE OF DEATH</b> Month <b>October</b> Day <b>2</b> Year <b>1961</b>			
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. Married</b> <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>Aug. 4, 1870</b>	<b>9. AGE</b> (last birthday) <b>91</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.

<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>At home</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> - - -		<b>11. BIRTHPLACE</b> (City and state or country) <b>Washburn, Mo.</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A.</b>	
<b>13a. FATHER'S NAME</b> <b>John Adcock</b>			<b>13b. MOTHER'S MAIDEN NAME</b> <b>Martha George</b>			<b>14. NAME OF HUSBAND OR WIFE</b> <b>Oscar Stewart</b>	

<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT</b> Address <b>2000 Washington, Kansas City, Mo.</b> <b>Mrs. Louise Schoenhoff, Kansas City, Mo.</b>	
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<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> DUE TO (b) <b>ARTERIO SCLEROSIS</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>12 years</b>
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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)	
<b>20c. TIME OF INJURY</b> Hour Month, Day, Year a.m. p.m.			

<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE	
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21. I attended the deceased from 1-1-61 to 10-2-61 and last saw her alive on 10-2-61  
 Death occurred at 6:00 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

<b>22a. SIGNATURE</b> (Degree or title) <i>Paul Laurence Paul Laurence M.D.</i>	<b>22b. ADDRESS</b> <b>428 South White Ave</b>	<b>22c. DATE SIGNED</b> <b>10-2-61</b>
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<b>23. BURIAL, CREMATION, OR REMOVAL</b> (Specify) <b>Cremation</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Elmwood Crematory</b>	<b>23d. LOCATION</b> (City, town, or county) (State) <b>Kansas City, Mo.</b>
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<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>Freeman Mortuary, Kansas City, Mo.</b>	<b>25. DATE RECD. BY LOCAL REG.</b> <b>10-3-61</b>	<b>26. REGISTRAR'S SIGNATURE</b> <i>Ruth Long</i>
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

DOCUMENT

BY AFFIDAVIT OF Paul Laurence Paul Laurence M.D.

ITEM NO. 1 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 Lawrence Freeman

Licensed Embalmer No. 5098

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.