SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

ITMENT OF PUBLIC HEALTH AND WELFARE

-61-037310

STATE FILE NUMBER

AMENDED

FILED NOV 8 1961

Registration District No. 146 Primary Registration District No. 4237 Registrar's No. 537

1. PLACE OF DEATH
a. COUNTY: Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Raytown — Length of stay in 1b: 35 yes.
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): 6517 Raytown Rd. — 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: Raytown — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 6517 Raytown Rd. — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Josie Middle: L. Last: Conway
4. DATE OF DEATH: Month: Nov. Day: 1 Year: 61
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 10-8-1874
9. AGE (last birthday): 87
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: —
11. BIRTHPLACE (City and state or country): Henry Co. Mo.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: unknown
13b. MOTHER'S MAIDEN NAME: unknown
14. NAME OF HUSBAND OR WIFE: unknown
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.: None
17. INFORMANT: Charles Philip Conway — Address: 6540 Raytown Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 10-31-61
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Myocardial Degeneration — 8-1-61
DUE TO (c): Posterior Wall Infarct — 8-1-61
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): age
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 April 1959, to 11-1-61 and last saw her/him alive on 1:05 P. 11/1/61
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: G Torcangelo (Degree or title) D.O.
22b. ADDRESS: 4137 Blue Ridge Blvd. Raytown
22c. DATE SIGNED: 11-1-61

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 11-4-1961
23c. NAME OF CEMETERY OR CREMATORY: Brooking Cem.
23d. LOCATION (City, town, or county) (State): Raytown Mo
24. FUNERAL DIRECTOR: Hinton Funeral Home — ADDRESS: Raytown, Mo.
25. DATE RECD. BY LOCAL REG.: 11-4-61
26. REGISTRAR'S SIGNATURE: Alba L. Craig

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO. | BY AFFIDAVIT OF | DOCUMENT

**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 John R. Sidm

Licensed Embalmer No. 4531

P. O. Address Kansas Cit

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl 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.