

# SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

MENT OF PUBLIC HEALTH AND WELFARE

-61-041012

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5665

AMENDED

**FILED DEC 1 1961**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>JACKSON</b> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b> Length of stay in 1b <b>35 YEARS</b> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>5900 SWOPE PARKWAY SWOPE RIDGE NURSING H.</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b> c. CITY OR TOWN <b>KANSAS CITY</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <b>323 BRUSH CREEK BLVD</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
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<b>3. NAME OF DECEASED</b> First Middle Last <b>GRACE S. DODDS</b>			<b>4. DATE OF DEATH</b> Month Day Year <b>NOVEMBER 11 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"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>6/10/70</b>	<b>9. AGE (last birthday)</b> <b>91</b>	<b>IF UNDER 1 YEAR</b> Months Days 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>HASTINGS, MICHIGAN</b>	
<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U. S. A.</b>			<b>13a. FATHER'S NAME</b> <b>MACUS B. STEBBINS</b>		
<b>13b. MOTHER'S MAIDEN NAME</b> <b>JENNIE MORGAN</b>			<b>14. NAME OF HUSBAND OR WIFE</b> <b>ROWAN T. F. DODDS</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>17. INFORMANT</b> <b>MRS. E. M. DODDS</b>	

<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>Arteriosclerosis the Heart Dis. 5 years</b> 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 (e) <b>no</b> PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		INTERVAL BETWEEN ONSET AND DEATH
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<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" 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"/> <b>NOT WHILE AT WORK</b> <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>	<b>COUNTY</b>	<b>STATE</b>
<b>21. I attended the deceased from</b> <u>June 59</u> <b>to</b> <u>7/11/61</u> <b>and last saw her</b> <u>11/9/61</u> <b>alive on</b> <b>Death occurred at</b> <u>7:00 A. M.</u> <b>on the date stated above, and to the best of my knowledge, from the causes stated.</b>				

<b>22a. SIGNATURE</b> (If force or title) <i>D. Bennett</i>	<b>22b. ADDRESS</b> <b>409 E 63rd St. C. Mo</b>	<b>22c. DATE SIGNED</b> <b>11/11/61</b>
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>	<b>23b. DATE</b> <b>NOV. 13, '61</b>	<b>23c. NAME OF CEMETERY OF</b> <b>MT. MORIAH CEMETERY</b>
<b>23d. LOCATION (City, town, or county)</b> <b>KANSAS CITY MISSOURI</b>		<b>23e. STATE</b>

<b>24. FUNERAL DIRECTOR</b> <b>D.W. NEWCOMER'S SONS KANSAS CITY, MO.</b>	<b>25. DATE RECD. BY LOCAL REG.</b> <b>11-13-61</b>	<b>26. REGISTRAR'S SIGNATURE</b> <i>Ruth Long</i>
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DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SHOULD READ

ITEM NO.

**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 Raymond M. Hardy

Licensed Embalmer No. 4913

P. O. Address Indeys. 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.