

# SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-041156

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5846 STATE FILE NUMBER

AMENDED  
**FILED DEC 11 1961**

DATE AMENDED

INSTEAD OF

DOCUMENT

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>JACKSON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u>		c. CITY OR TOWN <u>KANSAS CITY</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>3711 EAST 11<sup>TH</sup></u>		d. STREET ADDRESS (If outside, give location) <u>3600 E. 12<sup>TH</sup> ST.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>L.</u> Last <u>McGRIN</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>21</u> Year <u>1961</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>CACU.</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7/16/1879</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME MAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>DENISON, IOWA</u>
10c. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>JAMES OWENS</u>		13b. MOTHER'S MAIDEN NAME <u>JENNIE REECE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		17. INFORMANT <u>THOMAS McGRIN</u> Address <u>3600 E. 12<sup>TH</sup></u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cyclogenous nephritis</u> DUE TO (c) <u>Malnutrition</u>			INTERVAL BETWEEN ONSET AND DEATH
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
19. WAS AUTOPSY PERFORMED? YES <input 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 <u>1959</u> to <u>Nov. 20, 1961</u> and last saw her/him alive on <u>Nov. 20, 1961</u> . Death occurred at <u>6:45 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>H. Langmaid D.O.</u>		22b. ADDRESS <u>3337 1/2 Troost Ave</u>	22c. DATE SIGNED <u>11-22-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>NOV. 24, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CALVARY CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>KANSAS CITY Mo.</u>
24. FUNERAL DIRECTOR <u>Muehlebach</u>	ADDRESS <u>6800 Troost</u>	25. DATE RECD. BY LOCAL REG. <u>11-22-61</u>	26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>

ITEM NO. SHOULD READ

BY AFFIDAVIT OF  
H. Langmaid

*Dr. Langmaid, D.O.*

*3337 1/2 Street*

*WE 1-6401*

*1 to 5 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 *Dale L. Martin*

Licensed Embalmer No. *5106*

P. O. Address *Spencer, Kansas*

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.