

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-041185

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 5731

STATE FILE NUMBER

AMENDED

FILED DEC 11 1961

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 62 yrs	c. CITY OR TOWN Kansas City Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 6941 Montgall		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 6941 Montgall Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First David Middle H. Last Mounts			4. DATE OF DEATH Month Nov. Day 14 Year 1961
5. SEX Male	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 1-23-1881
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction	9. AGE (last birthday) 80 IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HR: Hours <input type="checkbox"/> Min. <input type="checkbox"/>
11. BIRTHPLACE (City and state or country) New Amsterdam, Ind. USA		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Samuel A. Mounts		13b. MOTHER'S MAIDEN NAME Florence Wilson	14. NAME OF HUSBAND OR WIFE Emma Mae Mounts
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service) No		17. INFORMANT Address K. C. Mo Mrs. Homer Mounts, 6941 Montgall	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis DUE TO (b) Arteriosclerosis DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 1 yr. yes.
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 Apr 10 58 to Nov 14-61 and last saw her alive on Nov 11-61 Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) John O Skinner MD		22b. ADDRESS 1402 Bryant Bldg.	22c. DATE SIGNED 11-15-61
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 11-17-61	23c. NAME OF CEMETERY OR CREMATORY Floral Hills, Inc	23d. LOCATION (City, town, or county) (State) Kansas City, Missouri
24. FUNERAL DIRECTOR ADDRESS Floral Hills Memorial Chapels, Inc Blue Ridge & Gregory		25. DATE RECD. BY LOCAL REG. 11-16-61	26. REGISTRAR'S SIGNATURE Ruth Long

(Licensed Embalmer's Statement on Reverse Side)

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 *[Handwritten Signature]*

Licensed Embalmer No. 3453

P. O. Address *[Handwritten 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.