

ISSUORI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

5503-61-041247
STATE FILE NUMBER

AMENDED

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

FILED NOV 17 1961

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

Comer Bates

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 Clay			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 1 Day 2 1/2 yrs		c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Trinity Lutheran Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 6109 North Euclid Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Eunice Middle Arlene Last Russell			4. DATE OF DEATH Month November Day 2 , Year 1961		
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9-11-1921	9. AGE (last birthday) 40	IF UNDER 1 YEAR Months 0 Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (City and state or country) Kansas City, Kansas	
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME Thomas Moore		13b. MOTHER'S MAIDEN NAME Minnie E. Millighan	
14. NAME OF HUSBAND OR WIFE James T. Russell,		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO			
17. INFORMANT James T. Russell, 6109 N. Euclid, K.C.Mo.				Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute intoxication					INTERVAL BETWEEN ONSET AND DEATH 18 hours
DUE TO (b) Reactive Depression					4-6 weeks
DUE TO (c) Chronic illness - Diabetes + Pulmonary insufficiency					10 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Previous pulmonary tuberculosis with control					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
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" 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 8:10 AM Month, Day, Year November 2, 1961					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 August 1, 1961 to November 2, 1961 and last saw her alive on November 1, 1961 Death occurred at 8:10 AM November 2, 1961 on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE B. Comer Bates, M.D.			22b. ADDRESS 2730 South Mall Kansas City 19, Missouri		22c. DATE SIGNED 11/3/61
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11-4-61	23c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery		23d. LOCATION (City, town, or county) (State) Kansas City, Kansas
24. FUNERAL DIRECTOR Melody-McGilley-Eylar,		ADDRESS 20 W. Linwood K. C. Mo.		25. DATE RECD. BY LOCAL REG. 11-3-61	26. REGISTRAR'S SIGNATURE Ruth Long

(Licensed Embalmer's Statement on Reverse Side)

G. Comer B
2730 Ro. 7
Bl =
1 to 5

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 Wm H Dentz

Licensed Embalmer No. 5038

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.