

MISSOURI DIVISION OF PUBLIC HEALTH AND WELFARE — STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

5655

STATE FILE NUMBER 41352

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

AMENDED

FILED DEC 1 1961

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 70 YEARS	c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF DECEASED (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DOA Baptist Memorial Hosp		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) 727 E. 72nd Terrace Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First CLAUDE Middle STANDIFORD Last YOUNG			4. DATE OF DEATH Month 11 Day 8 Year 1961			
5. SEX Male	6. COLOR OR RACE Caucasian	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2-21-91	9. AGE (last birthday) 70	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proctor & Gamble (Ret)		10b. KIND OF BUSINESS OR INDUSTRY MILLWRIGHT Soap		11. BIRTHPLACE (City and state or country) Kansas City, Mo.	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME WILLIAM M. YOUNG		13b. MOTHER'S MAIDEN NAME NANNIE STANDIFORD		14. NAME OF DECEASED'S WIFE Mrs. Grace Young	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO			17. INFORMANT M. Mrs. Grace Young, 727 E. 72nd Terrace Address Kansas City, Mo.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 1 hour
DUE TO (b) arteriosclerosis		
DUE TO (c) _____		

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		
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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
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21. I attended the deceased from **OCT 24, 1961** to **Nov 8, 1961** and last saw her/him alive on **Nov 8, 1961**
Death occurred at **2:35 P.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>William F. Sanders</i>	(Degree or title)	22b. ADDRESS 411 Nichols Rd KC-Mo	22c. DATE SIGNED 11/10/61
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23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE NOV. 11, 1961	23c. NAME OF CEMETERY OR CREMATOR MT. MORIAH CEMETERY	23d. LOCATION (City, town, or county) KANSAS CITY MISSOURI
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24. FUNERAL DIRECTOR D.W. NEWCOMER'S SONS	ADDRESS 1331 BRUSHCR. KANSAS CITY, MO	25. DATE RECD. BY LOCAL REG. 11-11-61	26. REGISTRAR'S SIGNATURE <i>Ruth Long</i>
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

DOCUMENT

BY AFFIDAVIT OF

William F. Sanders MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

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 Leub, Michael

Licensed Embalmer No. 4340

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.