ISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

RTMENT OF PUBLIC HEALTH AND WELFARE

-61-043937
STATE FILE NUMBER

AMENDED

Registration District No. 72 Primary Registration District No. 3013 Registrar's No. 233

FILED JAN 2 1962

DATE AMENDED

1. PLACE OF DEATH
a. COUNTY: CLAY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: NORTH KANSAS CITY — Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: D.O.A. N.K.C. Memorial — Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MO. b. COUNTY: CLAY
c. CITY OR TOWN: NORTH KANSAS CITY — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 2011 E. 26th AVE. — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First ROBERT Middle L. Last CANTRELL
4. DATE OF DEATH: Month 12 Day 26 Year 1961

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 11-16-1897
9. AGE (last birthday): 64 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HR: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED INTERNATIONAL
10b. KIND OF BUSINESS OR INDUSTRY: MILLING COMPANY
11. BIRTHPLACE (City and state or country): DADE COUNTY, MO.
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: WILLIAM SANDERS
13b. MOTHER'S MAIDEN NAME: LARA TERRELL
14. NAME OF HUSBAND OR WIFE: NORA CANTRELL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO. (If yes, give war or dates of service): *
17. INFORMANT: MRS. JOSEPH WEST — Address: 608 E. 76th GLADSTONE

INSTEAD OF

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) RESPIRATORY FAILURE — INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) BROUCHO AORTIC FISTULA

DUE TO (c) ANEURYSM AORTA ARTERIO SCLEROTICTYPE

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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 1958 to 1961 and last saw ~~him~~ alive on Dec 1961

Death occurred at 4:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Edward L. Mullins MD (Degree or title)
22b. ADDRESS: 1806 Swift St. North K.C. Mo.
22c. DATE SIGNED: 12-28-61

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: 12-28-1961
23c. NAME OF CEMETERY OR CREMATORY: FAIRVIEW CEMETERY
23d. LOCATION (City, town, or county) (State): LIBERTY MO.

24. FUNERAL DIRECTOR — ADDRESS: D.W. NEWCOMERS SONS N.K.C. MO.
25. DATE RECD. BY LOCAL REG.: 12-28-61
26. REGISTRAR'S SIGNATURE: Marguerite Hudgens

(Licensed Embalmer's Statement on Reverse Side)

SHOULD READ

ITEM NO.

BY AFFIDAVIT OF

DOCUMENT

JAN 5 1962

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 John V. Herrick Jr.

Licensed Embalmer No. 4848

P. O. Address K-6-17 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.