

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-044627

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 6601

STATE FILE NUMBER

1. PLACE OF DEATH  
 a. COUNTY Jackson  
 b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City Length of stay in lb 30 yrs  
 c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2118 Amie Inside Limits Yes  No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  
 a. STATE Mo. b. COUNTY Jackson  
 c. CITY OR TOWN Kansas City Inside Limits Yes  No   
 d. STREET ADDRESS (If outside, give location) 2118 Amie Reside on Farm Yes  No

3. NAME OF DECEASED (Type or print) First Middle Last 4. DATE OF DEATH Month Day Year  
JAMES COY DEARING 12-30-61

5. SEX Male 6. COLOR OR RACE White 7. Married  Never Married  Widowed  Divorced  8. DATE OF BIRTH 12-30-1906 9. AGE (last birthday) 55  
 IF UNDER 1 YEAR IF UNDER 24 HR  
 Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) machinist 10b. KIND OF BUSINESS OR INDUSTRY Sheet Metal 11. BIRTHPLACE (City and state or country) Harris, Mo. 12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME Jacob M. Dearing 13b. MOTHER'S MAIDEN NAME Berth Knox 14. NAME OF HUSBAND OR WIFE Marguerite Dearing

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No 17. INFORMANT Billy Joe Dearing address 1507 E. 7th St. KC 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 Occlusion  
 DUE TO (b) \_\_\_\_\_  
 DUE TO (c) \_\_\_\_\_  
 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Treated at Leavitt Ault  
 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 Month, Day, Year  
 a.m. p.m.

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 \_\_\_\_\_, to \_\_\_\_\_ and last saw him alive on \_\_\_\_\_  
 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) Hugh Owens 22b. ADDRESS 152 Union Station - 13-3066 22c. DATE SIGNED 1-2-62

23a. JOURNAL CREMATION, (Specify) Funeral 23b. DATE 1-2-1962 23c. NAME OF CEMETERY OR CREMATORY Cely Cemetery 23d. LOCATION (City, town, or county) (State) Savannah, Missouri

24. FUNERAL DIRECTOR Ch. Blackburn & Son, Inc. ADDRESS Kansas City, Missouri 25. DATE RECD. BY LOCAL REG. 1-2-62 26. REGISTRAR'S SIGNATURE Ruth Long

DATE AMENDED 1-3-62

INSTEAD OF married

BY AFFIDAVIT OF Informant divorced

DOCUMENT MEDICAL CERTIFICATION Owens

**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 W.C. Rinne

Licensed Embalmer No. 4879

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.