

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-044663

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 189 Primary Registration District No. 1002 Registrar's No. 5967 STATE FILE NUMBER 5967

**FILED DEC 18 1961**

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Jackson</b>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> COUNTY <b>Jackson</b> |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Kansas City</b>                  |  | Length of stay in 1b<br><b>3 wks</b>  | c. CITY OR TOWN <b>Raytown</b>  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Lake Side Hospital</b> |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location)<br><b>9100 E. 65th Terr</b> |
|  |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>   |   |

|   |                               |   |  |   |
|---|-------------------------------|---|--|---|
| 3. NAME OF DECEASED (Type or print)<br>First <b>Vivian</b> Middle <b>Frances</b> Last <b>Enright</b>            |                               |   | 4. DATE OF DEATH<br>Month <b>Nov.</b> Day <b>27</b> Year <b>1961</b> |   |
| 5. SEX <b>Female</b>  | 6. COLOR OR RACE <b>White</b> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <b>7-3-1904</b>                                     | 9. AGE (last birthday) <b>57</b>          |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b> |                               | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  | 11. BIRTHPLACE (City and state or country)<br><b>Kansas City, Mo</b> | 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b> |

|   |  |  |
|---|--|--|
| 13a. FATHER'S NAME<br><b>Wm. Maynard Pollock</b>  | 13b. MOTHER'S MAIDEN NAME<br><b>Myrtle Mae Jones</b> | 14. NAME OF HUSBAND OR WIFE<br><b>Emeret O. Enright</b>                              |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b> | 16. SOCIAL SECURITY NO.<br><b>None</b>               | 17. INFORMANT Address <b>Raytown, Mo</b><br><b>Emeret Enright, 9100 E. 65th Terr</b> |

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|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:                           |  | INTERVAL BETWEEN ONSET AND DEATH  |
| IMMEDIATE CAUSE (a)  | <b>Uremia</b>                                | <b>4 days</b>   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.   | DUE TO (b) <b>Generalized carcinomatosis</b> | <b>1 1/2 yrs</b>  |
|  | DUE TO (c) <b>Adenocarcinoma of ovary</b>    | <b>2 yrs.</b>   |
| 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.<br><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 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<br>Hour <input type="checkbox"/> a.m. <input type="checkbox"/> 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 **7-16-1959** to **Nov. 27th, 1961** and last saw **her** alive on **Nov. 26, 1961**  
Death occurred at **2:01 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

|   |   |  |
|---|---|--|
| 22. SIGNATURE (Degree or title)<br><b>J. M. Mauk, Jr. M.D.</b>        | 22b. ADDRESS<br><b>12007 E. 47th KC Mo.</b> | 22c. DATE SIGNED<br><b>11-27-61</b>                            |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>            | 23b. DATE<br><b>11-29-61</b>                | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Floral Hills, Inc</b> |
| 23d. LOCATION (City, town, or county)<br><b>Kansas City, Missouri</b> |   | (State)  |

|  |         |   |   |
|--|---------|---|---|
| 24. FUNERAL DIRECTOR<br><b>Floral Hills Memorial Chapels, Inc</b><br><b>Blue Ridge &amp; Gregory</b> | ADDRESS | 25. DATE RECD. BY LOCAL REG.<br><b>11-28-61</b> | 26. REGISTRAR'S SIGNATURE<br><b>Ruth Long</b> |
|--|---------|---|---|

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED  
INSTEAD OF  
DOCUMENT  
BY AFFIDAVIT OF  
ITEM NO. SHOULD READ

M. Mauk, Jr. MEDICAL CERTIFICATION

Dr. James Mack  
4721  
723-7957  
8:00  
7:00 P.M.

**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 *E. M. Jordan*

Licensed Embalmer No. 3453

P. O. Address H. C. Sta

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.