

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-044858

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 749 Primary Registration District No. 1002 Registrar's No. 6308
 FILED JAN 8 1962

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF E. Van Buskirk MEDICAL CERTIFICATION

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Jackson</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u> | | Length of stay in 1b <u>60 years</u> | c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>3404 Roberts</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>3404 Roberts</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Henry</u> Last <u>Lovell</u> | | 4. DATE OF DEATH Month <u>Dec.</u> Day <u>14</u> Year <u>1961</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>1-20-1879</u> 9. AGE (last birthday) <u>82</u> 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) | | 10b. KIND OF BUSINESS OR INDUSTRY <u>K. C. Power, Light</u> | 11. BIRTHPLACE (City and state or country) <u>Butler, Mo.</u> 12. CITIZEN OF WHAT COUNTRY <u>USA</u> |
| 13a. FATHER'S NAME <u>George L. Lovell</u> | | 13b. MOTHER'S MAIDEN NAME <u>Sarah E. Morgan</u> | 14. NAME OF HUSBAND OR WIFE <u>Catherine</u> |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> | | 17. INFORMANT Address <u>K. C. Mo.</u> <u>Mrs. Eula McCracken, 3404 Roberts</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute pulmonary edema</u> DUE TO (b) <u>Chronic myocarditis</u> DUE TO (c) <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>unknown</u> <u>unknown</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes mellitus - cerebral thrombosis</u> | | | 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 |
| 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 |
| 21. I attended the deceased from <u>11/27/61</u> to <u>12/14/61</u> and last saw him alive on <u>12/14/61</u> Death occurred at <u>home</u> - <u>8:45 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <u>J. E. Van Buskirk MD</u> | | 22b. ADDRESS <u>5246 St. John KCMo</u> | 22c. DATE SIGNED <u>12/15/61</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>12-16-1961</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Floral Hills, Inc</u> | 23d. LOCATION (City, town, or county) (State) <u>Kansas City, Missouri</u> |
| 24. FUNERAL DIRECTOR ADDRESS <u>Floral Hills Memorial Chapels, Inc</u> <u>Blue Ridge & Gregory</u> | | 25. DATE RECD. BY LOCAL REG. <u>12.16.61</u> | 26. REGISTRAR'S SIGNATURE <u>Ruth Long</u> |

Dr. Van
Bank
5246 St John
1-0141
WE 1-9500
to 4:30

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 *C. M. Janner*

Licensed Embalmer No. 3453

P. O. Address K. E. Kane

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.