

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

6563-61-044917

STATE FILE NUMBER

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

AMENDED

FILED JAN 15 1962

1. PLACE OF DEATH a. 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>15 Yrs</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u> c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>409 E. Armour</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Donald</u> Middle <u>J.</u> Last <u>Mills</u>		4. DATE OF DEATH Month <u>December</u> Day <u>28</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12-4-1901</u>
9. AGE (last birthday) <u>60 Yrs</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) <u>Sales Representative</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Union Carbide</u>	
11. BIRTHPLACE (City and state or country) <u>Monticello, Maine</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	
14. NAME OF HUSBAND OR WIFE <u>Kathryn Mills</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>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
		17. INFORMANT <u>Kathryn Mills 409 E. Armour</u> Address _____	
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>Cronay Occlusion</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. <u>DUE TO (b) Hypertensive heart disease</u> <u>DUE TO (c) Previous Cronay Occlusion</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Death 1 hour</u> <u>10+ years</u> <u>10+ years ago</u>
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
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>1949</u> to <u>Dec 28 1961</u> and last saw ^{her} him alive on <u>11-7-61</u> Death occurred at <u>1 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Frank B. Leitz M.D.</u>		22b. ADDRESS <u>1530 Park Pl. Fairport, Me</u>	
		22c. DATE SIGNED <u>12-28-61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>12-30-61</u>	23c. NAME OF CEMETERY OR CREMATORY _____	
23d. LOCATION (City, town, or county) (State) <u>Boston, Mass</u>			
24. FUNERAL DIRECTOR <u>Stine & McClure Kansas City, Missouri</u> ADDRESS _____		25. DATE RECD. BY LOCAL REG. <u>12-29-61</u>	
		26. REGISTRAR'S SIGNATURE <u>Keith Long</u>	

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Frank B. Leitz

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 _____

William M. Farnell

Licensed Embalmer No. _____

4648

P. O. Address _____

Kansas City

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.