

OURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-044918

MENT OF PUBLIC HEALTH AND WELFARE

6112

STATE FILE NUMBER

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6112

FILED DEC 22 1961

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY JACKSON | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI COUNTY JACKSON | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY | Length of stay in 1b 51 YEARS | c. CITY OR TOWN KANSAS CITY | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF IF NOT in hospital, give location) HOSPITAL OR INSTITUTION 2702 EAST LINWOOD LINMONT NURSING HOME | | d. STREET ADDRESS (If outside, give location) 3714 DENTON ROAD | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |

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|--|----------------------------------|---|---|---|---|--|
| 3. NAME OF DECEASED (Type or print) First ADDYE Middle L Last MINNICK | | | 4. DATE OF DEATH Month DECEMBER Day 2 Year 1961 | | | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH APR. 4, 86 | 9. AGE (last birthday) 75 | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY CORNISHVILLE | | 12. CITIZEN OF WHAT COUNTRY KENTUCKY U. S. A. | | |
| 13a. FATHER'S NAME WILLIAM SNODGRASS | | 13b. MOTHER'S MAIDEN NAME MARY FRANCES FUNK | | 14. NAME OF HUSBAND OR WIFE FRED R. MINNICK | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO | | | 17. INFORMANT FRED R. MINNICK | | | |

| | | |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <i>Coronary artery thrombosis</i> | | |
| DUE TO (b) <i>arteriosclerotic changes</i> | | |
| DUE TO (c) <i>hypertension</i> | | |
| 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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |

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|--|---|--|--|
| 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 Month, Day, Year a.m. p.m. | | | |
| 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>1957</u> to <u>Dec. 2, 1961</u> and last saw her ^{her} alive on <u>Dec. 2, 1961</u> Death occurred at <u>A.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <i>William B. Young</i> | | 22b. ADDRESS <u>12007 E 47</u> | 22c. DATE SIGNED <u>12/2/61</u> |
| 23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE DEC. 5, 1961 | 23c. NAME OF CEMETERY OR CREMATOR MEMORIAL PARK CEMETERY | 23d. LOCATION (City, town, or county) (State) KANSAS CITY MISSOURI |
| 24. FUNERAL DIRECTOR D.W. NEWCOMER'S SONS | | 25. DATE RECD. BY LOCAL REG. 2-5-61 | 26. REGISTRAR'S SIGNATURE <i>Ruth Long</i> |

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

William B. Young MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSEE

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.

personal supervision. **Student**

Signature of Student Embalmer

Signature of Student Embalmer

Signed

Marvin D. Presto

Licensed Embalmer No. 5040

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).

3: The above MUST BE signed by a STUDENT, he also shall sign in his OWN handwriting. If this body is not embalmed, fact should be so stated above.