

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-045013

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6023

FILED DEC 18 1961

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		Length of stay in 1b <b>50 yrs.</b>	c. CITY OR TOWN <b>KANSAS CITY</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. JOSEPH HOSPITAL</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>309 NO. WHEELING</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>F.</b> Last <b>ROSS</b>			4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>29</b> Year <b>1961</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>2-9-1906</b>	9. AGE (last birthday) <b>55</b> 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) <b>CORE MAKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>PRIER BRASS MFG. CO.</b>	11. BIRTHPLACE (City and state or country) <b>KANSAS CITY, KAS.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13a. FATHER'S NAME <b>WILLIAM L. ROSS</b>		13b. MOTHER'S MAIDEN NAME <b>MAMIE SCHMIDT</b>		14. NAME OF HUSBAND OR WIFE <b>LUCILLE H. ROSS</b>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b> <b>NO</b>		17. INFORMANT Address <b>Lucille Ross, 309 No. Wheeling, K.C., Mo.</b>	
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Terminal Bronchial Pneumonia 48 Hrs</b> DUE TO (c) <b>Pulmonary Emphysema</b> <b>Years</b>			INTERVAL BETWEEN ONSET AND DEATH <b>11-16-61</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. <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 11-21-61 to 11-29-61 and last saw him alive on 11-29-61  
Death occurred at 6:38 AM 11-29-61 on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Thos. C. McHale M.D.</b>	22b. ADDRESS <b>4601 Indep. Ave KCMo</b>	22c. DATE SIGNED <b>11-30-61</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>12-2-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>FLORAL HILLS CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>KANSAS CITY, MISSOURI</b>
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24. FUNERAL DIRECTOR ADDRESS <b>GEO. C. CARSON &amp; SONS, INDEPENDENCE, MO.</b>	25. DATE RECD. BY LOCAL REG. <b>11-30-61</b>	26. REGISTRAR'S SIGNATURE <b>Ruth Long</b>
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF  
**Thos. C. McHale**

ITEM NO. SHOULD READ

Dr. Nigro on Dr. W. Hale  
1222 Miller

**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 Marshall C. Blackwell

Licensed Embalmer No. 4713

P. O. Address Raytown, 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.