

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-045053

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED 149 Primary Registration District No. 1002 Registrar's No. 6004 STATE FILE NUMBER

FILED DEC 18 1961

1. PLACE OF DEATH a. COUNTY JACKSON b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY Length of stay in lb 24 years c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION RESEARCH HOSPITAL Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI COUNTY JACKSON c. CITY OR TOWN KANSAS CITY Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) 1309 BRUSH CREEK BLVD. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
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3. NAME OF DECEASED (Type or print) First CHESTER Middle W Last SIPE	4. DATE OF DEATH Month NOVEMBER Day 27 Year 1961
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5. SEX MALE	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 2/18/84	9. AGE (last birthday) 77	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Assistant State Auditor	10b. KIND OF BUSINESS OR INDUSTRY Auditor	11. BIRTHPLACE (City and state or country) Shelby, Ohio	12. CITIZEN OF WHAT COUNTRY U. S. A.
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13a. FATHER'S NAME William SIPE	13b. MOTHER'S MAIDEN NAME Clara Wilson	14. NAME OF HUSBAND OR WIFE Nadine P. Sipe
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	17. INFORMANT Address Mrs. Nadine P. Sipe, 1309 Brush Creek
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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) Cerebral Thrombosis DUE TO (b) arteriosclerosis DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	INTERVAL BETWEEN ONSET AND DEATH Sudden
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Prostate Hypertrophy	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
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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.)
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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"/>
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20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
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21. I attended the deceased from **11/20/61** to **11/27/61** and last saw him alive on **11/27/61**
 Death occurred at **2:45 P.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>Robert C. McClanahan, M.D.</i>	22b. ADDRESS 820 Professional Bldg	22c. DATE SIGNED 11/28/61
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Nov. 29, 1961	23c. NAME OF CEMETERY OR CREMATORY Centertown Cemetery	23d. LOCATION (City, town, or county) (State) Centertown Missouri
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24. FUNERAL DIRECTOR ADDRESS D.W. NEWCOMER'S SONS KANSAS CITY, MO. 11-29-61	25. DATE RECD. BY LOCAL REG. 11-29-61	26. REGISTRAR'S SIGNATURE <i>Ruth Long</i>
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DATE AMENDED: 12-1-61
 INSTEAD OF: William Sipe
 BY AFFIDAVIT OF Informant: Robert C. McClanahan
 ITEM NO.: 13a

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 Geneb. Michael

Licensed Embalmer No. 4340

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).

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.