

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-045232

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 146

Primary Registration District No. 3026

Registrar's No. 589

FILED DEC 20 1961

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson									
b. CITY (If outside corporate limits, give TOWNSHIP only) Independence Mo.			Length of stay in 1b 20 yrs		c. CITY OR TOWN Independence		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>						
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION 10535 Lake Dr.				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 10535 Lake Dr.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Harriett Middle G. Last Wuerz				4. DATE OF DEATH Month 12 Day 8 Year 61									
5. SEX Female		6. COLOR OR RACE White		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 8-25-1875		9. AGE (last birthday) 86		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) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Carthage Mo.		12. CITIZEN OF WHAT COUNTRY USA					
13a. FATHER'S NAME John Baboock				13b. MOTHER'S MAIDEN NAME Adeline Gooding				14. NAME OF HUSBAND OR WIFE Hugo wuerz					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. none		17. INFORMANT Irene Moaiarty 10535 Lake Dr. 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) Coronary occlusion DUE TO (b) Coronary Sclerosis - gen. arterio-sclerosis - 10 yrs DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH sudden			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease/condition given in PART I to Arterial Hypertension - arterio-sclerotic										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 1955 , to 1961 and last saw her alive on Dec 1960 Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) Field W. Hunk. M.D.						22b. ADDRESS 10229 Indep. Ave Indep. Mo			22c. DATE SIGNED 12/9/61				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-11-61		23c. NAME OF CEMETERY OR CREMATORY Forest Hill Cemetery			23d. LOCATION (City, town, or county) (State) Kansas City Missouri						
24. FUNERAL DIRECTOR Sheil Funeral Home K. C. Mo.				25. DATE RECD. BY LOCAL REG. 12-11-61		26. REGISTRAR'S SIGNATURE Alba L. Craig							

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JAN 16 1962

10229

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 Thomas A. Smith

Licensed Embalmer No. 4954

P. O. Address K. P. Me

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.