

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-002103

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 715

STATE FILE NUMBER

AMENDED

FILED FEB 15 1962

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits give TOWNSHIP only) OR TOWN <u>Waukegan Kansas City</u>	Length of stay in 1b <u>3 months</u>	c. CITY OR TOWN <u>Grandview</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital give location) HOSPITAL OR INSTITUTION <u>Jackson Co Hospital</u>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1102 Shelton</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN WILLIAM WANBAUGH</u>	4. DATE OF DEATH Month Day Year <u>Feb 4 1962</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 11 1864</u>	9. AGE (last birthday) <u>97</u>	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) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11. BIRTHPLACE (City and state or country) <u>Peru Indiana</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Jacob Wanbaugh</u>	13b. MOTHER'S MAIDEN NAME <u>Christine</u>	14. NAME OF HUSBAND OR WIFE <u>Sarepta Wanbaugh</u>
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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) <u>no</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT <u>Mrs Roy Lenn K C Hans.</u> Address <u>2328 Parallel</u>
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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) <u>Arteriosclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		

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
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	Month, Day, Year
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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
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21. I attended the deceased from 10-1-61 to 2-4-62 and last saw ^{her}him alive on 1-31-62
Death occurred at 8:30 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>J.P. McCalla, M.D.</u>	22b. ADDRESS <u>Jackson Co. Hospital Harrison City Mo</u>	22c. DATE SIGNED <u>Feb 6 1962</u>
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23. BURIAL, CREMATION, REMOVAL (City or county) <u>Funerary Home</u>	23b. DATE <u>Feb 6 1962</u>	24. NAME OF CEMETERY OR CREMATORY <u>Deerpunter Cemetery Chilhowee Mo.</u>	23d. LOCATION (City, town, or county) (State)
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25. FUNERAL DIRECTOR'S ADDRESS <u>Bunnenburg's Harrisonville Mo</u>	25. DATE RECD. BY LOCAL REG. <u>2-6-62</u>	26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>
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(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

BY AFFIDAVIT OF P. Mc Calla - MEDICAL CERTIFICATION DOCUMENT

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 Ernest R. Minnenburg

Licensed Embalmer No. 3368
P. O. Address Harrisonville

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.