

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-002145

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 537

FILED FEB 13 1962

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <b>Jackson</b>	b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Kansas City</b>	a. STATE <b>Missouri</b>	COUNTY <b>Jackson</b>
Length of stay in 1b <b>18 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>Forest Avenue Nursing Home</b>		d. STREET ADDRESS <b>2542 Woodland</b>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	4. DATE OF DEATH
<b>Doctor Wynn</b>	<b>Jan. 25 1962</b>

5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>8-30-96</b>	9. AGE (last birthday) <b>65</b>	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) <b>Farmer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	11. BIRTHPLACE (City and state or country) <b>Miller Co. Ark.</b>	12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>
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13a. FATHER'S NAME <b>Nelson Wynn</b>	13b. MOTHER'S MAIDEN NAME <b>Missouri De France</b>	14. NAME OF HUSBAND OR WIFE <b>None</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Alvin Wynn, 2905 Forest</b>	Address
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	<i>Hypostatic pneumonia</i>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	<i>Bilateral abscess of parotid glands</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I.		PART III. If deceased was female was there a pregnancy in last 90 days.
<i>Senility - arteriosclerotic heart disease</i>		<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.)
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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 Dec 61 to Jan - 62 and last saw her alive on Jan 24/62  
Death occurred at 9 AM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>J. E. Griffen</i>	(Degree or title)	22b. ADDRESS <b>3905 Perso KC Mo</b>	22c. DATE SIGNED <b>Jan 24/62</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>2-1-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Blue Ridge Lawn</b>	23d. LOCATION (City, town, or county) (State) <b>Kansas City, Mo.</b>
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24. FUNERAL DIRECTOR <b>Jones &amp; Stevens, 2315 Linwood Blvd.</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>1-29-62</b>	26. REGISTRAR'S SIGNATURE <i>Ruth N. Long</i>
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DATE AMENDED  
INSTEAD OF  
DOCUMENT  
BY AFFIDAVIT OF  
ITEM NO. SHOULD READ

J. E. GRIFFEN MEDICAL CERTIFICATION DO

**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 \_\_\_\_\_

Licensed Embalmer No. 4429

P. O. Address 2140 E. 1st St  
St. Louis, 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.