

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-006476

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1037

FILED MAR 7 1962

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) OR TOWN Kansas City		Length of stay in lb 40 yrs.	c. CITY OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Crethaven Nursing Home		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2818 East 11th Street		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MAUDE Middle ELIZABETH Last DeCLOUD			4. DATE OF DEATH Month February Day 20, Year 1962			
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 8-12-1879	9. AGE (last birthday) 82	
10a. USUAL OCCUPATION (Give kind of work done during at of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Albium, New York	12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Charles Treadway			13b. MOTHER'S MAIDEN NAME Marion Ballou		14. NAME OF HUSBAND OR WIFE Frank A.P. DeCloud	
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 Mrs. Earl Deputy, 310 W. 49th, Kansas City, Mo		
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 Hemorrhage					INTERVAL BETWEEN ONSET AND DEATH 7 days	
Conditions, if any, which gave rise to above cause - (a), stating the underlying cause last. DUE TO (b) Hypertension & Obesity					5 yrs.	
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	
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 checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION Kansas City		COUNTY Jackson	STATE Mo
21. I attended the deceased from Feb 14th - 62 to Feb 20 - 62 and last saw him alive on Feb 20 - 62, 445 p m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE Joseph Getelson M.D.			22b. ADDRESS 900 Rialto Bldg		22c. DATE SIGNED 2-21-62	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2.21.62	23c. NAME OF CEMETERY OR CREMATORY -		23d. LOCATION (City, town, or county) (State) Shawnee, Kansas.		
24. FUNERAL DIRECTOR Freeman Mortuary, Kansas City, Mo.			25. DATE RECD. BY LOCAL REG. 2-21-62		26. REGISTRAR'S SIGNATURE Ruth Long	

DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 Joseph Getelson
 ITEM NO. SHOULD READ

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. 4793

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.