

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-015421

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2172

DO NOT WRITE ON THIS STUB

AMENDED

FILED MAY 7 1962

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		c. CITY OR TOWN <b>Kansas City</b> <b>18808 Lawndale</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Jackson Co. Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>11808 Lawndale</b>	
3. NAME OF DECEASED (Type or print) First <b>Catherine</b> Middle <b>-----</b> Last <b>Reisinger</b>		4. DATE OF DEATH Month <b>April</b> Day <b>17</b> Year <b>1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</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>Oct. 7, 1962</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (City and state or country) <b>Freeport, Ill.</b>
12a. FATHER'S NAME <b>Unknown</b>		12b. MOTHER'S MAIDEN NAME <b>Unknown</b>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>		14. NAME OF HUSBAND OR WIFE <b>Deceased</b>	
15. SOCIAL SECURITY NO. <b>None</b>		16. -INFORMANT <b>R. S. Reisinger, Kansas City, Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> DUE TO (b) <b>Fracture of Hip 4-14-62</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Cerebral Hemorrhage 10 days</b>		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 _____ Month, Day, Year _____ a.m. _____ p.m. _____		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.) <b>Residence</b>		20f. CITY, TOWN, OR LOCATION <b>Grandview Jackson Mo</b>	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ 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) <b>Ruth H. Owens Coroner</b>		22b. ADDRESS <b>152 Union Station</b>	
22c. DATE SIGNED <b>4-17-62</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>April 17, 1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Winfield Cemetery</b>	23d. LOCATION (City, town, or county). (State) <b>Winfield, Kansas</b>
24. FUNERAL DIRECTOR <b>Langsford Funeral Home, Lee's Summit</b>		25. DATE RECD. BY LOCAL REG. <b>4-19-62</b>	26. REGISTRAR'S SIGNATURE <b>Ruth Long</b>

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF RUTH H. OWENS

USE BLACK INK OR TYPEWRITER RIBBON

VS 300  
Rev. 4/59

1
2 <b>3248</b>
3
4 <b>1</b>
5 <b>2</b>
6
7 <b>1</b>
8 <b>2</b>
9
10 <b>4</b>
11 <b>700</b>
12 <b>77-3</b>
13

See 4-3200

**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 W.B. Langford

Licensed Embalmer No. 5833

P. O. Address Lee's Summit  
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.