

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-015496

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1915

1915

FILED APR 20 1962

VS 300	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	DATE AMENDED
Rev. 4/59		
1		
23848		
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4 1		
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7 1		
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9170X		
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1250-0		
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	INSTEAD OF	
	DOCUMENT	
	BY AFFIDAVIT OF	
	MEDICAL CERTIFICATION	
	Charles S. Cooper	
	SHOULD READ	
	ITEM NO.	

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>Jackson</u>		a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Length of stay in 1b <u>16 Yrs</u>	c. CITY OR TOWN <u>Kansas City</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>Baptist Memorial</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1000 West 59th Terrace</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED First Middle Last			4. DATE OF DEATH Month Day Year
<u>Avis Marie Sunderland</u>			<u>April 4 1962</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3-13-1898</u>
9. AGE (last birthday) <u>64 Yrs</u>		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) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (City and state or country) <u>Richland Center Wisconsin</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Schyler Peters</u>	
13b. MOTHER'S MAIDEN NAME <u>Martha Morris</u>		14. NAME OF HUSBAND OR WIFE <u>Paul Sunderland</u>	
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 Address <u>K.C., Mo. Paul Sunderland 1000 West 59th Terrace</u>
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) <u>Inanition</u>			<u>3 months</u>
DUE TO (b) <u>Metastasis, bony, well spread</u>			<u>18 months</u>
DUE TO (c) <u>Cancer of left breast,</u>			<u>14 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Broncho pneumonia, mild</u>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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			
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 <u>Aug. 15, 1960</u> to <u>4-4-62</u> and last saw her alive on <u>4-4-62</u>			
Death occurred at <u>8:00 AM 4-4-62</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Charles S. Cooper M.D.</u>		22b. ADDRESS <u>618 Prof. Bldg. K.C. Mo.</u>	22c. DATE SIGNED <u>4-4-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Entombment</u>	23b. DATE <u>4-4-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Moriah Temple</u>	23d. LOCATION (City, town, or county) (State) <u>Kansas City, Missouri</u>
24. FUNERAL DIRECTOR ADDRESS <u>Stine & McClure Kansas City, Missouri</u>		25. DATE RECD. BY LOCAL REG. <u>4-5-62</u>	26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>

*Dr Charles Cooper
618 Prof. Bldg
Ba 1-2032
11-1-30 pm*

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 William M. Turner

Licensed Embalmer No. 4648

P. O. Address Kansas City, 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.