

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-022324

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 72 Primary Registration District No. 3013 Registrar's No. 115

VS 300
Rev. 4/59

6004
26002

3

4 0

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94201

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11

126-0

132-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FILED JUL 5 1962

1. PLACE OF DEATH a. COUNTY <u>Clay</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Clay</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>North Kansas City</u>		Length of stay in lb <u>6 1/2</u> days	c. CITY OR TOWN <u>Gladstone</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>North K. C. Memorial Hosp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>202 E. 67th Terrace No.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>FREDERICK FOREST IRISH</u>			4. DATE OF DEATH Month Day Year <u>June 29, 1962</u>			
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5. SEX <u>Male</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>10-12-1888</u>	9. AGE (last birthday) <u>73</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>Retired Printer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Commercial Printing Trade</u>	11. BIRTHPLACE (City and state or country) <u>Disco, Ind.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>William H. Irish</u>	13b. MOTHER'S MAIDEN NAME <u>Sarah Alice Darr</u>	14. NAME OF HUSBAND OR WIFE <u>Zellah Reed Irish</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>Yes W.W. I</u>	16. SOCIAL SECURITY NO. <u>W.W. I</u>	17. INFORMANT <u>Jack Irish</u> Address <u>5514 West 78th Terrace Prarie Village, Kansas</u>
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18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Circulatory Failure, Acute</u>		INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Hypertrophy of Heart</u>		<u>yrs</u>
	DUE TO (c) <u>Coronary Atherosclerosis</u>		<u>yrs</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cor pulmonale - previous asthma</u>		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 checked="" type="checkbox"/> NO <input 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 <u>December 1, 1957</u> to <u>June 29, 1962</u> and last saw him alive on <u>June 29, 1962</u>	
Death occurred at <u>10:55 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.	

22a. SIGNATURE (Degree or title) <u>J. Corner Bates M.D.</u>	22b. ADDRESS <u>5140 Antioch Road K.C. 19, Mo.</u>	22c. DATE SIGNED <u>6-30-62</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>7-2-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Chapel Hills Memorial Garden</u>	23d. LOCATION (City, town, or county) (State) <u>Wyandotte County, Kansas</u>
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24. FUNERAL DIRECTOR ADDRESS <u>HARRY BUTLER FUNERAL HOME, INC. Box 11068 Antioch Station K.C. 19, MO.</u>	25. DATE RECD. BY LOCAL REG. <u>7-2-62</u>	26. REGISTRAR'S SIGNATURE <u>Marquerite Anderson</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK OR TYPEWRITER RIBBON

JUL 6 1962

JUL 31 1962
MAR 19 1963

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 E. P. Gibson

Licensed Embalmer No. 4137

P. O. Address 100 W

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.