

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-011947
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1755

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1
23578
3
4 1
5 2
6
7 1
8 0
9332X
10
11
1265-0
13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

BY AFFIDAVIT OF
George K. Boyd

FILED APR 1 1963							
<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>JACKSON</u></p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u> Length of stay in 1b <u>4 mo</u></p> <p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. JOSEPH HOSPITAL</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE <u>MO.</u> b. COUNTY <u>JACKSON</u></p> <p>c. CITY OR TOWN <u>KANSAS CITY</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) <u>3721 BALES</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>						
<p>3. NAME OF DECEASED First Middle Last <u>CARRIE M. SUTTER</u></p> <p>4. DATE OF DEATH Month Day Year <u>MARCH 16 1963</u></p>							
<p>5. SEX <u>FEMALE</u></p>	<p>6. COLOR OR RACE <u>CAUC</u></p>	<p>7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <u>4-10-1871</u> 9. AGE (last birthday) <u>91</u> YEARS</p>	<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u></p>	<p>10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u></p>	<p>11. BIRTHPLACE (City and state or country) <u>MANHATTAN KANSAS</u></p>	<p>12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u></p>
<p>13a. FATHER'S NAME <u>PETER DENOVER</u></p>		<p>13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u></p>		<p>14. NAME OF HUSBAND OR WIFE <u>O.J. SUTTER (DECEASED)</u></p>			
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u></p>		<p>16. SOCIAL SECURITY NO.</p>		<p>17. INFORMANT <u>VERA HAMILTON 410 E. DADEN INDEP. MO.</u></p>			
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u></p> <p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral Insufficiency</u> <u>3 days</u></p> <p>DUE TO (c) <u>Cerebral Vascular Occlusion</u> <u>3 days</u></p>							<p>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</p>
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Pulmonary Embolism + Pneumonitis</u></p>							
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></p>	<p>20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/></p>	<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)</p>					
<p>20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year</p>							
<p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p>	<p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	<p>20f. CITY, TOWN, OR LOCATION COUNTY STATE</p>					
<p>21. I attended the deceased from <u>12 March 63</u> to <u>present</u> and last saw her alive on <u>3-16-63</u></p> <p>Death occurred at <u>7:30 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.</p>							
<p>22a. SIGNATURE (Degree or title) <u>George K Boyd MD</u></p>			<p>22b. ADDRESS <u>5711 Independence Ave</u></p>		<p>22c. DATE SIGNED <u>3/18/63</u></p>		
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u></p>	<p>23b. DATE <u>3-19-1963</u></p>	<p>23c. NAME OF CEMETERY OR CREMATORY <u>FOREST HILL CEMETERY</u></p>		<p>23d. LOCATION (City, town, or county) (State) <u>KANSAS CITY, MISSOURI</u></p>			
<p>24. FUNERAL DIRECTOR <u>MUEHLEBACH</u> ADDRESS <u>6800 TROOST AVE.</u></p>			<p>25. DATE RECD. BY LOCAL REG. <u>3-18-63</u></p>		<p>26. REGISTRAR'S SIGNATURE <u>Ruth Long</u></p>		

D.K. Boyd
5111 Indep. Ave
Be 1-7943

AFTER 1:00 P.M. until 5.00

0-20
0-1
0-6
0-8

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 Robert L. Landes

Licensed Embalmer No. 5103

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.