

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-000641

FILED VS. FEB 15 1960 59

Registration District No. 4097 Registrar's No. 29

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Cass</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cass</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Harrisonville</u>		Length of stay in 1b		c. CITY OR TOWN <u>Harrisonville</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>Highway 71</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Highway 71</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>NORMAN</u> Middle <u>NATHAN</u> Last <u>URTON</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>31</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 16 1880</u>	9. AGE (last birthday) <u>79</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bridge Foreman</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (City and state or country) <u>Cass Co Mo. U.S.A</u>		12. CITIZEN OF WHAT COUNTRY
13a. FATHER'S NAME <u>Chas B Urton</u>			13b. MOTHER'S MAIDEN NAME <u>Amanda Parr</u>		14. NAME OF HUSBAND OR WIFE <u>Bertie Urton</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>MRS EFFIE GROSE 1107 E 11th St KANSAS CITY MO</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>5-10 minutes</u>
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 checked="" 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.) <u>Coronary occlusion</u>				
20c. TIME OF INJURY Hour <u>12:45</u> Month, Day, Year <u>1/31/60</u> 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.) <u>home</u>		20f. CITY, TOWN, OR LOCATION <u>Harrisonville</u> COUNTY <u>Cass</u> STATE <u>MO</u>
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <u>12:45</u> P.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Robert C. Phillips D.C. Coroner</u>			22b. ADDRESS <u>Harrisonville 302 S. Independence St. Mo.</u>		22c. DATE SIGNED <u>2/1/60</u>		
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Feb 3 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oakland Cemetery</u>		23d. LOCATION (City, town, or county) <u>Harrisonville Mo.</u> (State)		23e. REGISTRAR'S SIGNATURE <u>Ms Day Sebree</u>
24. FUNERAL DIRECTOR <u>Wm. H. Burgess Harrisonville Mo.</u> ADDRESS <u>Harrisonville Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>Feb-2-1960</u>		26. REGISTRAR'S SIGNATURE <u>Ms Day Sebree</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FEB 19 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Frank E. Runnenberg

Licensed Embalmer No. 5073

P. O. Address Harrisonville

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.