

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-014545

FILED VS MAY 5 1960

Registration District No. 71 Primary Registration District No. 3012 Registrar's No. 41

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>CLAY</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>EXCELSIOR SPRINGS</u> Length of stay in 1b <u>YEARS</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>310 MARION</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>CLAY</u> c. CITY OR TOWN <u>EXCELSIOR SPRINGS</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>310 MARION</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM THOMAS CAZHCAEZ</u>			4. DATE OF DEATH Month Day Year <u>APRIL 19 1960</u>				
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>2-12-1897</u>	9. AGE (last birthday) <u>63</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>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CONSTRUCTION</u>		11. BIRTHPLACE (City and state or country) <u>BERNICE, IOWA</u>			
13a. FATHER'S NAME <u>JAMES CAZHCAEZ</u>		13b. MOTHER'S MAIDEN NAME <u>JEANEZZE ROSS</u>		14. NAME OF HUSBAND OR WIFE <u>MURIEL LAMB</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>487-07-0678</u>		17. INFORMANT Address <u>MRS MURIEL CAZHCAEZ, SPRINGS, 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>Shot gun wound to upper MID EPIGASTRIC IN.</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>20 GA. Double Barrel.</u>				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)			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 checked="" 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 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 _____ to _____ and last saw her 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) <u>O. J. Pate M.D. Coroner</u>			22b. ADDRESS <u>North Kansas City Mo.</u>		22c. DATE SIGNED <u>4/19/60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>4-21-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LAWSON</u>		23d. LOCATION (City, town, or county) (State) <u>LAWSON, MISSOURI</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Richard Funeral Home, Inc.</u> <u>Excelsior Springs, Missouri</u>			25. DATE RECD. BY LOCAL REG. <u>4-29-60</u>		26. REGISTRAR'S SIGNATURE <u>Caroline Hutchings</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MAY 24 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 Ralph Van Landingham

Licensed Embalmer No. 4009

P. O. Address Folsom Springs, N.C.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.