URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS JUL 5 1960

3260 -60-023323

STATE FILE NUMBER

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

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City
Length of stay in 1b 50 years
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION General Hospital
Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Jackson
c. CITY OR TOWN Kansas City
Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 1312 W. 20 Terr
Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First: Clem Middle: LeRoy Last: O'Rear

4. DATE OF DEATH Month: June Day: 16 Year: 1960

5. SEX: Male

6. COLOR OR RACE: Caus.

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: Sept 24, 1900

9. AGE (last birthday): 59

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): Auto Trimmer

10b. KIND OF BUSINESS OR INDUSTRY: Auto Seat Covers

11. BIRTHPLACE (City and state or country): Foster, Missouri

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Marcus O'Rear

13b. MOTHER'S MAIDEN NAME: Madora Hensen

14. NAME OF HUSBAND OR WIFE: Alice O'Rear

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 564-12-0672

17. INFORMANT: Mrs. Alice O'Rear Address: 1312 W. 20 Terr

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Basilar artery thrombosis with mid brain infarction

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)

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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 6-14-60, to 6-16-60 and last saw her/him alive on 6-16-60

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) H L Dwyer MD

22b. ADDRESS 2400 Cherry

22c. DATE SIGNED 6-20-60.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: June 20, 1960

23c. NAME OF CEMETERY OR CREMATORY: Salem Cemetery

23d. LOCATION (City, town, or county) (State): Foster, Missouri

24. FUNERAL DIRECTOR: Muehlebach ADDRESS: 6800 Troost

25. DATE RECD. BY LOCAL REG.: 6-20-60

26. REGISTRAR'S SIGNATURE: Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF H. L. Dwyer MEDICAL CERTIFICATION DOCUMENT

NDED

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_____ Signed J. T. Crowell

Signature of Student Embalmer

Licensed Embalmer No. 490

P. O. Address K. C. M

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