

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-041322

FILED VS NOV 28 1960

STATE FILE NUMBER

Registration District No. 59 Primary Registration District No. 4697 Registrar's No. 194

DED

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 ^{7b} <u>6 weeks</u>	c. CITY OR TOWN <u>Harrisonville</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Memorial Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>502 So Independence</u>
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>ELLIS HUDSON BIRD</u>			4. DATE OF DEATH Month Day Year <u>Nov 14 1960</u>	
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5. SEX <u>Female</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>Oct 29 1873</u>	9. AGE (last birthday) <u>87</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Cass Co Mo USA</u>	12. CITIZEN OF WHAT COUNTRY
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13a. FATHER'S NAME <u>John H Hudson</u>	13b. MOTHER'S MAIDEN NAME <u>Sallie A. Davis</u>	14. NAME OF HUSBAND OR WIFE <u>Chas Bird</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>No</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT <u>Harry H. Beard</u> Address <u>Harrisonville</u>
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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>CEREBRAL THROMBOSIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 WKS</u>
DUE TO (b) <u>CEREBRAL ARTERIOSCLEROSIS</u>		
DUE TO (c) _____		
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 checked="" 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 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 1957 to Nov 14 1960 last saw him alive on 11-14-60
Death occurred at 6 AM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>J C Moody MD</u> (Degree or title)	22b. ADDRESS <u>Harrisonville Mo</u>	22c. DATE SIGNED <u>11-16-60</u>
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23a. BURIAL, CREATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Nov 16 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Orient Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Harrisonville Mo.</u>
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24. FUNERAL DIRECTOR <u>Brunnenburger's Harrisonville Mo</u> ADDRESS	25. DATE RECD. BY LOCAL REG. <u>11-15-60</u>	26. REGISTRAR'S SIGNATURE <u>Mrs Ray Seber</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

0961 68 AON

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 Ernest R. Rasmussen

Licensed Embalmer No. 3368

P. O. Address Harrison

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.