

# FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-042301

FILED VS NOV 17 1960

149

Primary Registration District No. 1002

Registrar's No. 5492

STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Jackson</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Length of stay in 1b <u>42 yrs.</u>		c. CITY OR TOWN <u>Kansas City</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>3610 Warwick</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>3610 Warwick Blvd.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Bert</u> Middle <u>E.</u> Last <u>Stratton</u>				<b>4. DATE OF DEATH</b> Month <u>Oct.</u> Day <u>28,</u> Year <u>1960</u>									
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. Married</b> <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Jan. 31-1888</u>		<b>9. AGE</b> (last birthday) <u>72</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Salesman</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Insurance</u>				<b>11. BIRTHPLACE</b> (City and state or country) <u>Pawhattan, Kansas</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U. S. A.</u>			
<b>13a. FATHER'S NAME</b> <u>Arthur E. Stratton</u>				<b>13b. MOTHER'S MAIDEN NAME</b> <u>Carrie Rife</u>				<b>14. NAME OF HUSBAND OR WIFE</b> <u>Dala Stratton</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> <u>514-24-6178</u>		<b>17. INFORMANT</b> <u>Dorothea M. Stricker, 2518 W. 97th Ter.</u>							
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u>										INTERVAL BETWEEN ONSET AND DEATH <u>MOMENTS</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u>										<u>15 YEARS</u>			
DUE TO (c) _____										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			
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			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input checked="" type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) _____									
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m.		Month, Day, Year _____		_____									
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		<b>20f. CITY, TOWN, OR LOCATION</b> _____		COUNTY _____ STATE _____		_____					
<b>21. I attended the deceased from</b> <u>June 1958</u> to <u>Oct. 28, 1960</u> and last saw <sup>her</sup> him alive on <u>Oct. 27, 1960</u> Death occurred at <u>9:30</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.													
<b>22a. SIGNATURE</b> <u>George K. Landis, M.D.</u> (Degree or title)					<b>22b. ADDRESS</b> <u>1103 Grand Avenue KCMO</u>					<b>22c. DATE SIGNED</b> <u>10/28/60</u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Removal</u>		<b>23b. DATE</b> <u>10-31-60</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Powhattan, Kansas</u>			<b>23d. LOCATION</b> (City, town, or county) (State) <u>Pawhattan, Kansas</u>						
<b>24. FUNERAL DIRECTOR</b> <u>Stine &amp; McClure, Kansas City, Mo.</u>					ADDRESS _____		<b>25. DATE RECD. BY LOCAL REG.</b> <u>10-31-60</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>H L Dwyer</u>				

DOCUMENT

MEDICAL CERTIFICATION Landis MD

George K.

BY AFFIDAVIT OF

**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

*Joe B. Godes*

Licensed Embalmer No. 4173

P. O. Address K. C. 9th

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.