

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-046513

FILED VS. JAN 6 1967  
 IDED

Registration District No. 150 Primary Registration District No. 5574 Registrar's No. 267 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Jackson</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sni A Bar, Twp</u>		Length of stay in -lb. <u>4hrs</u>		c. CITY OR TOWN <u>Blue Springs</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>Lake Tawapungo Blue Springs Mo</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>509 So 9th</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Earl</u> Middle <u>÷</u> Last <u>Pack</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>26</u> Year <u>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>10-29-1895</u>	9. AGE (last birthday) <u>65</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>Maintenance</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>man</u>		11. BIRTHPLACE (City and state or country) <u>Blue Springs Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Archie Pack</u>			13b. MOTHER'S MAIDEN NAME <u>Emma Bowlin</u>			14. NAME OF HUSBAND OR WIFE <u>Bessie</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes #1</u>			16. SOCIAL SECURITY NO. <u>496-10-8137</u>		17. INFORMANT Address <u>Bessie Pack Blue 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>Acute coronary occlusion</u> DUE TO (b) <u>Arterial sclerotic heart disease</u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>14yr</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 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.)						
20c. TIME OF INJURY Hour <u>  </u> Month, Day, Year <u>  </u>		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 <u>11-5-60</u> to <u>12-26-60</u> and last saw her/him alive on <u>12-23-60</u> Death occurred at <u>12:30 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>Merrill R. Bay M.D.</u>				22b. ADDRESS <u>Blue Springs Mo</u>			22c. DATE SIGNED <u>12-27-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Dec 28-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Blue Springs Cem</u>		23d. LOCATION (City, town, or county) (State) <u>Blue Springs Mo</u>			
24. FUNERAL DIRECTOR ADDRESS <u>Webb Funeral Home Blue Springs Mo</u>				25. DATE RECD. BY LOCAL REG. <u>12-30-1960</u>		26. REGISTRAR'S SIGNATURE <u>M. B. Langford</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JAN 6 1961

MAR 3 1961

**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 William E. Free

Licensed Embalmer No. 473

P. O. Address Blue Spring

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.