

## MISSOURI DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH AND WELFARE

Registration District No. 149

Primary Registration District No. 1602

Registrar's No.

292-61-001215

DATE FILED

AMENDED

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		Length of stay in lb <b>2 YEARS</b>		c. CITY OR TOWN <b>KANSAS CITY</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>LAKESIDE HOSPITAL</b>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>3128 TRACY AVENUE</b>	
3. NAME OF DECEASED (Type or print) First <b>DAISY</b> Middle <b>MABLE</b> Last <b>ARTHUR</b>				4. DATE OF DEATH Month <b>1</b> Day <b>17</b> Year <b>1961</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>CAUCASIAN</b>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>3-31-1881</b>	
9. AGE (last birthday) <b>79</b>		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) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (City and state or country) <b>GRAFTON, ILLINOIS</b>	
12. CITIZEN OF WHAT COUNTRY <b>USA</b>							
13a. FATHER'S NAME <b>JASPER TIMMONS</b>				13b. MOTHER'S MAIDEN NAME <b>FLORENCE WORTHEY</b>		14. NAME OF HUSBAND OR WIFE <b>JAMES ARTHUR</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>496-26-2875</b>		17. INFORMANT <b>MRS GUY BAKER</b> Address <b>3128 Tracy, KC, MO.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypostatic Pneumonia</b> DUE TO (b) <b>CVA.</b> DUE TO (c) <b>Arteriosclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>28 hours</b> <b>24 hours</b> <b>5 yrs</b>
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 _____ a.m. _____ p.m.		Month, Day, Year _____					
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 <b>1958</b> to <b>Jan 17 61</b> and last saw <sup>her</sup> alive on <b>Jan 17 1961</b> Death occurred at <b>10:45</b> <b>P</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <i>[Signature]</i> (Degree or title)				22b. ADDRESS <b>1400 E 831st KC Mo</b>		22c. DATE SIGNED <b>1/18/61</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE <b>JAN. 19, 1961</b>		23c. NAME OF CEMETERY OR CREATOR <b>VANDALIA CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>VANDALIA MISSOURI</b>	
24. FUNERAL DIRECTOR <b>D.W. NEWCOMER'S SONS</b> ADDRESS <b>1331 BRUSH CREEK KANSAS CITY, MO.</b>				25. DATE RECD. BY LOCAL REG. <b>1-18-61</b>		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

ITEM NO.

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 me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed James W. Stegner  
Licensed Embalmer No. 3780  
P. O. Address K. C. Mo

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.