

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-009106

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 749 Primary Registration District No. 1002 Registrar's No. 940

FILED VS MAR 13 1961

1. PLACE OF DEATH a. COUNTY JACKSON			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Length of stay in 1b 35 yrs.	c. CITY OR TOWN KANSAS CITY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. MARY'S HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 107 NORTH TOPPING		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First RAY Middle R. Last SCEARCE			4. DATE OF DEATH Month FEBRUARY Day 20 Year 1961		
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12-3-1925	9. AGE (last birthday) 35	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY JIM SCEARCE, INC.	11. BIRTHPLACE (City and state or country) KANSAS CITY, MO.		12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME GEORGE D. SCEARCE		13b. MOTHER'S MAIDEN NAME NOAHM R. HOFFMAN		14. NAME OF HUSBAND OR WIFE DELORES SCEARCE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. !		17. INFORMANT Address Delores Scearce, 107 N. Topping, K.C., Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Post Operative Hemorrhage & Shock					INTERVAL BETWEEN ONSET AND DEATH 5 h
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Replacement of ligature from Renal Artery Stump					5 h.
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Hypernephroma right kidney				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 checked="" type="checkbox"/> NO <input 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 Month, Day, Year a.m. p.m.					
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 Aug. -60 to Feb 20 - 61 and last saw ^{her} him alive on Feb 20, 61 Death occurred at 8:35 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Robert L. Ward M.D.			22b. ADDRESS 4126 St John		22c. DATE SIGNED 2-21-61
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 2-23-61	23c. NAME OF CEMETERY OR CREMATORY SALEM CEMETERY		23d. LOCATION (City, town, or county) (State) JACKSON COUNTY, MO.
24. FUNERAL DIRECTOR GEO. C. CARSON & SONS, INDEPENDENCE, MO.		ADDRESS	25. DATE RECD. BY LOCAL REG. 2-22-61	26. REGISTRAR'S SIGNATURE Ruth Long	

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF **Robert L. Ward**

VS MAR 13 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 me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Dean W. Huff

Licensed Embalmer No. 4914

P. O. Address Indy, 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.