

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-013982

AMENDED

Registration District No. 199 Primary Registration District No. 1002 Registrar's No. 1929

STATE FILE NUMBER

FILED MAY 8 1961

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <b>JACKSON</b>		a. STATE <b>MISSOURI</b> COUNTY <b>CLAY</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>	Length of stay in 1b <b>39 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>ST. LUKE'S HOSPITAL</b>		d. STREET ADDRESS (If outside, give location) <b>4026 N. Cleveland</b>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First <b>SAMUEL</b>	Middle	Last <b>SHURBACK</b>	4. DATE OF DEATH	Month <b>APRIL</b>	Day <b>17</b>	Year <b>1961</b>
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5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>2/8/97</b>	9. AGE (last birthday) <b>64</b>	IF UNDER 1 YEAR	IF UNDER 24 HR
				Months	Days	Hours

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DIVISION SUPERINTENDANT</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>CORN PRODUCTS</b>	11. BIRTHPLACE (City and state or country) <b>POLAND</b>	12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>
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13a. FATHER'S NAME <b>UNKNOWN</b>	13b. MOTHER'S MAIDEN NAME <b>SHURBACK</b>	14. NAME OF <del>husband</del> OR WIFE <b>DOROTHY SHURBACK</b>
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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) <b>NO</b>	16. SOCIAL SECURITY NO.	17. INFORMANT <b>DOROTHY SHURBACK</b>	Address <b>4026 N. CLEVELAND KANSAS CITY, MO.</b>
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Carcinomatosis</b>		<b>3 Mo</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Carcinoma of lung</b>	<b>18 Mo.</b>
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 type="checkbox"/> No <input type="checkbox"/> Unknown
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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.)
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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
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21. I attended the deceased from Nov. 4/59 to April 17/61 and last saw him alive on April 17/61  
 Death occurred at \_\_\_\_\_ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>L. Spafford M.D.</b>	22b. ADDRESS <b>315 Nichols Rd Kansas City, Mo</b>	22c. DATE SIGNED <b>4/18/61</b>
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23a. BURIAL CREMATION REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>APR. 19, 61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MOUND GROVE CEMETERY</b>	23d. LOCATION (City, town, or county) <b>INDEPENDENCE MISSOURI</b>
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24. FUNERAL DIRECTOR <b>D.W. NEWCOMER'S SONS CITY, MO.</b>	ADDRESS <b>NORTH KANSAS</b>	25. DATE RECD. BY LOCAL REG. <b>4-19-61</b>	26. REGISTRAR'S SIGNATURE <b>Ruth Long</b>
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(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 DATE AMENDED  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 BY AFFIDAVIT OF  
 L. Spafford  
 ITEM NO. SHOULD READ

**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 Chester K Brown

Licensed Embalmer No. 4931

P. O. Address KEMO

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.