

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

2423-61-017378  
STATE FILE NUMBER

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2423

DECEASED JUN 5 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>Jackson</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>	Length of stay in 1b <b>Life</b>	c. CITY OR TOWN <b>Lees Summit</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</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>Route #4</b>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH	
First <b>PAMELA</b>	Middle <b>RAE</b>	Last <b>CURTIS</b>	Month <b>May</b>	Day <b>16</b> Year <b>1961</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>5/16/61</b>	9. AGE (last birthday)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Kansas City, MO.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>

13a. FATHER'S NAME <b>Jack Edward Curtis</b>	13b. MOTHER'S MAIDEN NAME <b>Virginia M Lang</b>	14. NAME OF HUSBAND OR WIFE <b>—</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>None</b>	17. INFORMANT Address <b>Jack E Curtis Route #4 Lees Summit</b>

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>Intra Uterine Anoxia</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	<b>Asphyxia</b>	
DUE TO (b)	<b>Prenatal - Prematurity</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

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 5-16-61 to 5-16-61 and last saw her/him alive on 5-16-61  
Death occurred at 9:45 AM - 5-16-61 AM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Dr. Friedman</i>	(Degree or title)	22b. ADDRESS <b>7204 Prospect, K.C. Mo</b>	22c. DATE SIGNED <b>5-16-61</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>May 17 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt Washington Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>Kansas City Missouri</b>

24. FUNERAL DIRECTOR <b>Shell Funeral Home Kansas City Mo</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>5-17-61</b>	26. REGISTRAR'S SIGNATURE <i>Ruth Long</i>
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT BY AFFIDAVIT OF *Fredman Weinberg* MEDICAL CERTIFICATION

