

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-017446

ED MAY 29 1961

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2359 STATE FILE NUMBER

AMENDED

DATE AMENDED

INSTEAD OF

DOCUMENT

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 TOWN/RIP only) <u>Wasson City</u>		c. CITY OR TOWN <u>Wasson City</u>	
Length of stay in 1b <u>10 yrs</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF DECEASED (If NOT in hospital, give location) <u>General Hosp.</u>		d. STREET ADDRESS (If outside give location) <u>3225 Charlotte</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Charles Roy</u> Middle <u>Ford</u> Last <u>Ford</u>			4. DATE OF DEATH Month <u>5</u> Day <u>12</u> Year <u>61</u>			
---	--	--	---	--	--	--

5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1/20/89</u>	9. AGE (last birthday) <u>72</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>FILTER - CONTRACTING</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>PIPE UNKNOWN, MINNESOTA</u>	11. BIRTHPLACE (City and state or country) <u>U. S. A.</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>
--	---	---	--

13a. FATHER'S NAME <u>UNKNOWN FORD</u>	13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	14. NAME OF HUSBAND OR WIFE <u> </u>
---	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	17. INFORMANT <u>MRS. STELLA MATHEWS KANSAS CITY, 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>arcuana (Bronchogenic)</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. - DUE TO (b) <u>of the Right lung</u> <u>with</u> - DUE TO (c) <u>metastases</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> a.m. <u> </u> p.m. <u> </u>	Month, Day, Year <u> </u>
---	----------------------------

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u> </u>	COUNTY <u> </u>	STATE <u> </u>
---	--	---	---------------------	--------------------

21. I attended the deceased from <u>5-8-61</u> to <u>5-12-61</u> and last saw him alive on <u>5-12-61</u> Death occurred at <u>4:45 a.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE <u>[Signature]</u> (Degree or title)	22b. ADDRESS <u>2400 Perry City</u>	22c. DATE SIGNED <u>5/12/61</u>
--	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>MAY 15, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CALVARY CEMETERY</u>	23d. LOCATION (City, town, or county) <u>KANSAS CITY MISSOURI</u>
--	----------------------------------	---	--

24. FUNERAL DIRECTOR <u>D.W. NEWCOMER'S SONS</u> ADDRESS <u>1331 BRUSH CR. KANSAS CITY, MO.</u>	25. DATE RECD. BY LOCAL REG. <u>5-12-61</u>	26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>
--	--	---

(Licensed Embalmer's Statement on Reverse Side)

ITEM NO. SHOULD READ

BY AFFIDAVIT OF Frank Ellis

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

Lemb. Michael

Licensed Embalmer No. 4340

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.