

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-017743

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 2080

STATE FILE NUMBER

AMENDED

FILED MAY 17 1961

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Jackson			
b. CITY (If outside corporate limits, give TOWNSHIP only) Kansas City		Length of stay in 1b 20 yrs		c. CITY OR TOWN Kansas City		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph Hosp.				d. STREET ADDRESS (If outside, give location) 3411 E. 36th st.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELLEN Middle C. Last ROLD			4. DATE OF DEATH Month April Day 25 Year 1961				
5. SEX female	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6-19-93	9. AGE (last birthday) 67	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) school cafeteria		10b. KIND OF BUSINESS OR INDUSTRY Central Junior		11. BIRTHPLACE (City and state or country) Avoca Iowa		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Dennis Gorman			13b. MOTHER'S MAIDEN NAME Mary Ann Shannahan			14. NAME OF HUSBAND OR WIFE Olive D. Rold	
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 Mrs. Mary E. Chrisciana-		Address Corpus, Chr. Texas
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary heart failure DUE TO (b) arteriosclerotic heart disease DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 2 weeks unknown	
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 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 April 12, 1961 , to April 25, 1961 and last saw her alive on April 25, 1961 Death occurred at 8:30 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Albert K Decker MD				22b. ADDRESS Kansas City, Mo.		22c. DATE SIGNED 4/26/61	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 4-27-61	23c. NAME OF CEMETERY OR CREMATORY St. Mary's		23d. LOCATION (City, town, or county) Avoca, Iowa		(State)
24. FUNERAL DIRECTOR Melody-McGilley-Eylar			ADDRESS 1800 E. Linwood		25. DATE RECD. BY LOCAL REG. 4-26-61		26. REGISTRAR'S SIGNATURE Ruth Long

Die Hunter, Becker, & Kets
Kollheim Bldg.

Vi. 2. - 10. 708

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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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.