

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-012792

STATE FILE NUMBER

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2124

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

FILED MAY 17 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 **20 yrs**

c. CITY OR TOWN **Kansas City** Inside Limits Yes No

d. STREET ADDRESS (If outside, give location) **6237 E. 12th. Terr.** Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First **Sylvia** Middle **O.** Last **Speake**

4. DATE OF DEATH Month **4** Day **29** Year **61**

5. SEX **Female** 6. COLOR OR RACE **White** 7. Married Never Married Widowed Divorced

8. DATE OF BIRTH **7-9-1906** 9. AGE (last birthday) **54** IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HR

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Housewife** 10b. KIND OF BUSINESS OR INDUSTRY **Webster Co. Mo.** 11. BIRTHPLACE (City and state or country) **Webster Co. Mo.** 12. CITIZEN OF WHAT COUNTRY **U.S.S.A.**

13a. FATHER'S NAME **James H. Greathouse** 13b. MOTHER'S MAIDEN NAME **Bertha Terry** 14. NAME OF HUSBAND OR WIFE **Otis Speake**

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 **Otis Speake 6237 E. 12th. Terr.**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Metastatic carcinoma to pleura, liver, spine** 9 months
DUE TO (b) **adenocarcinoma of breast (surgically removed)** 9 months
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. Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 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 NOT WHILE AT WORK 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 **3-15-60** to **4-29-61** and last saw her alive on **4-28-61**
Death occurred at **3:00 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) **Richard W. Gunn M.D.** 22b. ADDRESS **1001 Professional Bldg. K.C., Mo.** 22c. DATE SIGNED **4-29-61**

23a. BURIAL CREMATION, REMOVAL (Specify) **Burial** 23b. DATE **5-2-61** 23c. NAME OF CEMETERY OR CREMATORY **Mt. Washington Cemetery Independence Mo.** 23d. LOCATION (City, town, or county) (State)

24. FUNERAL DIRECTOR **Sheil Funeral Home K. C. Missouri** ADDRESS **4-29-61** 25. DATE-RECD. BY LOCAL REG. 26. REGISTRAR'S SIGNATURE **Ruth Long**

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 Richard E. Carroll

Licensed Embalmer No. 4829

P. O. Address KC 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.