

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-017860

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2233 STATE FILE NUMBER

AMENDED

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

FILED MAY 19 1961

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) OR TOWN KANSAS CITY		c. CITY OR TOWN KANSAS CITY	
Length of stay in 1b 4 YRS		Inside Limits <input type="checkbox"/> Outside Limits <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION SWOPE RIDGE NURSING HOME		d. STREET ADDRESS (If outside, give location) 5900 SWOPE PKWY	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last GERTRUDE C WEAVER			4. DATE OF DEATH Month Day Year 5 4 61
5. SEX FE	6. COLOR OR RACE WH	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH NOV 7 1883
9. AGE (last birthday) 77		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) AT HOME		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) KANSAS
12. CITIZEN OF WHAT COUNTRY U.S.			
13a. FATHER'S NAME JOHN W CHADWICK		13b. MOTHER'S MAIDEN NAME SARAH C GRAHAM	14. NAME OF HUSBAND OR WIFE WILLARD B WEAVER
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, <input checked="" type="checkbox"/> unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	17. INFORMANT JOHN C WEAVER, 819 MADISON EVANSTON ILL
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage.</i> DUE TO (b) <i>Hypertension.</i> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
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 checked="" 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 <i>June 16-59</i> to <i>May 4-61</i> and last saw her alive on <i>April 29-61</i> . Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>H.P. Doughinou M.D.</i> (Degree or title)		22b. ADDRESS <i>K.P. Mo.</i>	22c. DATE SIGNED <i>5/5/61</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 5.6.61	23c. NAME OF CEMETERY OR CREMATORY FOREST HILL	23d. LOCATION (City, town, or county) KANSAS CITY MO
24. FUNERAL DIRECTOR STINE McCLURE K. C. MO. ADDRESS		25. DATE RECD. BY LOCAL REG. 5-5-61	26. REGISTRAR'S SIGNATURE <i>Ruth Long</i>

1330 10 3:00

**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 William M. Turner

Licensed Embalmer No. 4648

P. O. Address Kansas City

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.