

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**=61-021564**

STATE FILE NUMBER

AMENDED

Registration District No. 746 Primary Registration District No. 3026 Registrar's No. 311

**FILED JUN 20 1961**

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>INDEPENDENCE</b>		c. CITY OR TOWN <b>INDEPENDENCE</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>INDEP. SAN. &amp; HOSP.</b>		d. STREET ADDRESS (If outside, give location) <b>1009 SWOPE DRIVE</b>	
3. NAME OF DECEASED (Type or print) First <b>JENNIE</b> Middle <b>DANIELS</b> Last <b>DANIELS</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>13</b> Year <b>1961</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>10-20-1887</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DOMESTIC</b>	9. AGE (last birthday) <b>73</b>
13a. FATHER'S NAME <b>JOHN DRINKARD</b>		13b. MOTHER'S MAIDEN NAME <b>GERTRUDE SEARS</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</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>		17. INFORMANT Address <b>Albert Daniels, 1009 Swope Dr., K.C., Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Valvulus of ileum</b> DUE TO (b) <b>external hernia adhesions</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs</b> <b>yes</b>
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 <b>Mar. 1959</b> to <b>6/13/61</b> and last saw her <sup>her</sup> <sub>him</sub> give on <b>6/13/61</b> Death occurred at <b>11:15 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Vance E. Link M.D.</b>		22b. ADDRESS <b>10901 Waring Rd Independence Mo</b>	22c. DATE SIGNED <b>6/14/61</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>6-16-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MT. WASHINGTON CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>INDEPENDENCE, MISSOURI</b>
24. FUNERAL DIRECTOR ADDRESS <b>GEO. C. CARSON &amp; SONS, INDEPENDENCE, MO.</b>		25. DATE RECD. BY LOCAL REG. <b>6-16-61</b>	26. REGISTRAR'S SIGNATURE <b>Alba L. Ciaro</b>

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

**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 Dean W. Huff

Licensed Embalmer No. 49164

P. O. Address Indy., 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.