

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-025474
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1-002 Registrar's No. 3485

FILED JUL 28 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 Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 60 Years	c. CITY OR TOWN Kansas City
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Lindeman Nursing Home		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 5050 Oak Street
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES EUGENE SCOVERN		4. DATE OF DEATH Month Day Year July 11, 1961	
5. SEX Male	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 1-30-1872
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Accountant		10b. KIND OF BUSINESS OR INDUSTRY Jefferson City, Mo.	9. AGE (last birthday) 89
13a. FATHER'S NAME Sam Scovern		13b. MOTHER'S MAIDEN NAME Pauline Wagner	12. CITIZEN OF WHAT COUNTRY U.S.A.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		14. NAME OF HUSBAND OR WIFE Grace Scovern	
17. INFORMANT Miss Virginia Scovern, Kansas City, Mo.		Address 5050 Oak Street.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarct Secute DUE TO (b) Arteriosclerosis Generalized 20 yrs DUE TO (c) Fracture left hip PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 1 1/2 Hours
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 Nov 1958 to July 11 61 and last saw her him alive on July 9, 61 Death occurred at 4:30 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (In ink or type) D. Bennett MD		22b. ADDRESS 409 E 63rd St KC Mo	22c. DATE SIGNED 7/12/61
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE July 13, 1961	23c. NAME OF CEMETERY OR CREMATORY Mount Moriah Cemetery	23d. LOCATION (City, town, or county) (State) Kansas City, Missouri.
24. FUNERAL DIRECTOR Freeman Mortuary, Kansas City, Mo.		ADDRESS	25. DATE RECD. BY LOCAL REG. 7-12-61
			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 Clayton A. Barner

Licensed Embalmer No. 4793

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.