

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-032711

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4701

AMENDED

FILED OCT 4 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 50 years	c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Swope Ridge Nursing Home 5900 Swope Parkway		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4235 Locust Street Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First St. CLAIR Middle ALEXANDER Last			4. DATE OF DEATH Month September Day 21 Year 1961		
--	--	--	---	--	--

5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 5/19/69	9. AGE (last birthday) 92	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
-----------------------	----------------------------------	---	------------------------------------	-------------------------------------	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Auditor	10b. KIND OF BUSINESS OR INDUSTRY Mckesson & Robbins	11. BIRTHPLACE (City and state or country) St. Clairs Village Ohio	12. CITIZEN OF WHAT COUNTRY U. S. A.
---	--	--	--

13a. FATHER'S NAME Ross James Alexander	13b. MOTHER'S MAIDEN NAME Margaretta Askew	14. NAME OF HUSBAND OR WIFE -
---	--	---

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. None	17. INFORMANT John W. Brand, Lawrence, Kansas Address
---	--	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 2 days
DUE TO (b) Cerebral Arteriosclerosis		5-10 Yrs.
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. <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 <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	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 Dec. 1955 to 21 Sept. 61 and last saw ^{her} _{him} live on 19 Sept 1961 Death occurred at 6:50 A. m on the date stated above, and to the best of my knowledge, from the causes stated.	
---	--

22a. SIGNATURE (Degree or title) Philip G. Keul MD.	22b. ADDRESS 711 Nichols Road	22c. DATE SIGNED 9-21-61
---	---	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE 9/22/1961	23c. NAME OF EMBALMER OR CREMATORY D.W. Newcomer's Sons	23d. LOCATION (City, town, or county) (State) Kansas City Missouri
---	-------------------------------	--	--

24. FUNERAL DIRECTOR D.W. Newcomer's Sons Address 1331 Brush Creek Blvd. Kansas City, Mo.	25. DATE RECD. BY LOCAL REG. 9-21-61	26. REGISTRAR'S SIGNATURE Ruth Long
---	--	---

(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 Philip G. Keul
 SHOULD READ
 ITEM NO.

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 Harold E. Cullern

Licensed Embalmer No. 3035
P. O. Address La Crosse

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.