

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

4733-61-032728
STATE FILE NUMBER

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4733

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 1 yr.	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 1305 Summit		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1305 Summit Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First PHYLLIS Middle JEANNE Last BARRICK			4. DATE OF DEATH Month 9 Day 21 Year 61	
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5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12-25-29	9. AGE (last birthday) 31	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Key Punch & I.B.M. Oper.	10b. KIND OF BUSINESS OR INDUSTRY Armour & Co.	11. BIRTHPLACE (City and state or country) Kansas City, Kansas	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Clyde Calvin Jacobs	13b. MOTHER'S MAIDEN NAME Peggy Hough	14. NAME OF HUSBAND OR WIFE Roy Barrick
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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 Mrs. Rose Jacobs : 6139 Grandview	Address Merriam, Kansas
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u><i>Drinking fat liver</i></u> acute alcoholism		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	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
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year
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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 _____
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21. I attended the deceased from _____ to _____ and last saw her/him alive on _____
Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u><i>Phyllis Jeanne Barrick</i></u> (Degree or title)	22b. ADDRESS <u><i>6627 Brookside Dr</i></u>	22c. DATE SIGNED <u><i>9-22-61</i></u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 9-26-61	23c. NAME OF CEMETERY OR CREMATORY MOUNT CALVARY CEM.	23d. LOCATION (City, town, or county) (State) Kansas City, Kansas
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24. FUNERAL DIRECTOR Weilert Funeral Homes (w) K.C., Mo.	25. DATE RECD. BY LOCAL REG. 9-23-61	26. REGISTRAR'S SIGNATURE <u><i>Ruth Long</i></u>
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DATE AMENDED

INSTEAD OF DOCUMENT

BY AFFIDAVIT OF

100. S. Keilhofer MEDICAL CERTIFICATION

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 B. E. Weibert

Licensed Embalmer No. 4075

P. O. Address 3 E. 8, 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: