

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-032787

STATE FILE NUMBER

149

Registration District No. Primary Registration District No. 1602 Registrar's No.

4510

AMENDED

FILED SEP 25 1961

| | | | | | |
|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Jackson | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Jackson | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City | | Length of Residence 20 yrs. | c. CITY OR TOWN Independence | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Marys Hosp. | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 1201 W. Linden | |
| 3. NAME OF DECEASED (Type or print) First MARY Middle K. Last COMPTON | | | 4. DATE OF DEATH Month Sept. Day 10, Year 1961 | | |
| 5. SEX female | 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 8-18-1900 | 9. AGE (last birthday) 61 | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse | | 10b. KIND OF BUSINESS OR INDUSTRY Nursing | | 11. BIRTHPLACE (City and state or country) Canada | |
| 12. CITIZEN OF WHAT COUNTRY U. S. A. | | | 13a. FATHER'S NAME Patrick Keaney | | |
| 13b. MOTHER'S MAIDEN NAME Bridget Moran | | | 14. NAME OF HUSBAND OR WIFE Harry H. Compton, Sr. | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None | | 16. SOCIAL | | 17. INFORMANT Address 9936 Charlotte Mrs. William Steiner Kan. City, Mo. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adeno Carcinoma Colon Metastases 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 |
| 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 1960 to 1961 and last saw her/him alive on 9/10/61 Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE (Degree or title) J. Cochran M.D. | | | 22b. ADDRESS 4706 Broadway | | 22c. DATE SIGNED 9/11/61 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE Sept. 12, 1961 | 23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet | | 23d. LOCATION (City, town, or county) (State) Kansas City, Missouri | |
| 24. FUNERAL DIRECTOR ADDRESS Geo. C. Carson & Sons Ind. Mo. | | | 25. DATE RECD. BY LOCAL REG. 9-11-61 | 26. REGISTRAR'S SIGNATURE Ruth Long | |

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 J. Cochran
 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 *Charles J. Taylor*

Licensed Embalmer No. 4534

P. O. Address Liberty Md

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.