

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-033028

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4673

STATE FILE NUMBER

AMENDED

DATE AMENDED

INSTEAD OF

DOCUMENT

<b>FILED OCT 4 1961</b> a. COUNTY <b>JACKSON</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> COUNTY <b>CLAY</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		Length of stay in lb <b>2 DAYS</b>	c. CITY OR TOWN <b>AVONDALE</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>RESEARCH HOSPITAL</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>2934 CATES AVENUE</b>	
3. NAME OF DECEASED (Type or print) First <b>AMY</b> Middle <b>SUE</b> Last <b>MYNATT</b>			4. DATE OF DEATH Month <b>SEPT.</b> Day <b>17</b> Year <b>1961</b>		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>9/15/61</b>	9. AGE (last birthday) IF UNDER 1 YEAR Months _____ Days <b>2</b>	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INFANT</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	11. BIRTHPLACE (City and state or country) <b>KANSAS CITY, MO.</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>
13a. FATHER'S NAME <b>OREN J. MYNATT</b>		13b. MOTHER'S MAIDEN NAME <b>DORIS AMOS</b>		14. NAME OF HUSBAND OR WIFE <b>--</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>		16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT Address <b>2934 CATES AVE.</b> <b>OREN J. MYNATT, AVONADLE, 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) <u>Prematurity</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>premature labor</u> 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					INTERVAL BETWEEN ONSET AND DEATH
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 _____ 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 <u>9-15-61</u> to <u>9-17-61</u> and last saw her/him alive on <u>9-17-61</u> Death occurred at <u>9:00 AM Sept 17, 1961</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Gene A. Schillie</u> (Degree or title)			22b. ADDRESS <u>425 E 63 K.E. Mo.</u>		22c. DATE SIGNED <u>9-18-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>SEPT. 19, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>WHICH CHAPEL CEMETERY</b>		23d. LOCATION (City, town, or county) <b>CLAY CO., MISSOURI</b>	(State)
24. FUNERAL DIRECTOR <b>D.W. NEWCOMERS SONS, NKC., MO.</b>		25. DATE RECD. BY LOCAL REG. <b>9-19-61</b>		26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>	

(Licensed Embalmer's Statement on Reverse Side)

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

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 Genob. Michael

Licensed Embalmer No. 4340

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.