

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-035927

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 1108

STATE FILE NUMBER

AMENDED

FILED Nov 6 1961

1. PLACE OF DEATH a. COUNTY Buchanan			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 St. Joseph		Length of stay in 1b 30 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 State Hospital #2		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) 700 E. 43rd		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Della Middle Baer Last			4. DATE OF DEATH Month October Day 28 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 April 21, 1886	9. AGE (last birthday) 75	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Nebraska	12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME George Ireland		13b. MOTHER'S MAIDEN NAME Eva Collins		14. NAME OF HUSBAND OR WIFE (Deceased)		
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. Eva Baer, Kansas 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) Bronchopneumonia DUE TO (b) Senility and General Debility DUE TO (c) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH 1 week unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition giving rise to death A patient in this hospital since 9-15-1931 Diagnosed--Post Encephalitis					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 Month, Day, Year a.m. 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 Oct 28, 1961 to Oct. 28, 1961 and last saw her him alive on Oct. 28, 1961 Death occurred at 4:35 P on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) H.F. Mundy M.D.			22b. ADDRESS St Joseph Mo. Oct 28-1961		22c. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 10-28-1961	23c. NAME OF CEMETERY OR CREMATORIUM Kansas City, Missouri	23d. LOCATION (City, town, or county) (State)			
24. FUNERAL DIRECTOR D.W. Newcomer's Sons--Kansas City, Mo.		ADDRESS	25. DATE RECD. BY LOCAL REG. Oct. 28, 1961	26. REGISTRAR'S SIGNATURE Mrs. Clark Lordell		

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

H.F. Mundy, M.D. MEDICAL CERTIFICATION

NOV 6 1961

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 Harry E. Clemens

Licensed Embalmer No. 4050

P. O. Address Pleasant Hill

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.