

# SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-040147

MENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 1156

STATE FILE NUMBER

FILED NOV 20 1961

DATE AMENDED

INSTEAD OF

DOCUMENT

SHOULD READ

BY AFFIDAVIT OF

MEDICAL CERTIFICATION  
*M. T. Mohr, M.D.*

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clay</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>		Length of stay in 1b <u>5 weeks</u>		c. CITY OR TOWN <u>Excelsior Springs</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTIONS <u>St. Joseph Hospital No. 2</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Crown Hill Road</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Alden</u> Last <u>Apt</u>				4. DATE OF DEATH Month <u>November</u> Day <u>11</u> Year <u>1961</u>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>10-17-1877</u>		9. AGE (last birthday) <u>84</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Superintendent</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Cemetery</u>		11. BIRTHPLACE (City and state or country) <u>Carmen, Illinois</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>					
13a. FATHER'S NAME <u>Charles A. Apt</u>				13b. MOTHER'S MAIDEN NAME <u>Celia Miller</u>				14. NAME OF HUSBAND OR WIFE <u>Annie M. Burtlow</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs. Annie Apt, Excelsior Springs, Mo.</u>							
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>General Debility due to Aging</u>												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			
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 _____, to _____ and last saw him/her alive on <u>11-11-61</u> Death occurred at <u>3:00 a</u> _____ m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <i>M. T. Mohr, M.D.</i>						22b. ADDRESS <u>St. Joseph, Missouri</u>				22c. DATE SIGNED <u>11-11-61</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>11-11-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Masonic</u>		23d. LOCATION (City, town, or county) (State) <u>Excelsior Springs, Missouri</u>							
24. FUNERAL DIRECTOR ADDRESS <u>Pritchard Funeral Home, Inc.</u> <u>Excelsior Springs, Missouri</u>				25. DATE RECD. BY LOCAL REG. <u>Nov. 16, 1961</u>		26. REGISTRAR'S SIGNATURE <i>Mrs. Clark Handall</i>							

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 Amicus Jarama

Licensed Embalmer No. 4589  
P.O. Address Excelsior Springs

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.