

# SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-040976

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5836

AMENDED

**FILED** DEC 11 1961

a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>	Length of stay in 1b <b>38 years</b>	c. CITY OR TOWN <b>Kansas City</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>St. Joseph Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>717 E. 54th Street</b>
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>J.</b> Last <b>CAIN</b>			4. DATE OF DEATH Month <b>11</b> Day <b>19</b> Year <b>1961</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>10/31/71</b>	9. AGE (last birthday) <b>90</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>K.C. Agency</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Equitable Life Insurance Co.</b>		10c. CITY AND STATE (City and state or country) <b>Montgomery City, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>
13a. FATHER'S NAME <b>Thomas CAIN</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Sheridan</b>		14. NAME OF HUSBAND OR WIFE <b>Merly Cain</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>			17. INFORMANT <b>Merly Cain, 717 E. 54th Street</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs</b> <b>72 hrs.</b>
IMMEDIATE CAUSE (a)	<b>Shock</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	<b>Fracture of hip - fell out of bed.</b>	
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) <b>Carcinoma of Prostate with metastases</b>		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.)
20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> 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 May 27, 1960 to Nov 19, 1961 and last saw him alive on Nov 19, 1961  
Death occurred at 10:30 P. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Marion P. Hunter M.D.</b>		22b. ADDRESS <b>1408 Waldheim Bldg</b>	22c. DATE SIGNED <b>11/29/61</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>Nov. 23, 1961</b>	23c. NAME OF CEMETERY OF (Specify) <b>Fairview Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Galien Galion Ohio</b>

24. FUNERAL DIRECTOR <b>D.W. NEWCOMER'S SONS KANSAS CITY, MO.</b>	ADDRESS <b>1331 BRUSH CR.</b>	25. DATE RECD. BY LOCAL REG. <b>11-22-61</b>	26. REGISTRAR'S SIGNATURE <b>Ruth Long</b>
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

4/17/62

INSTEAD OF

10/31/71 DOCUMENT

SHOULD READ

10/13/71

ITEM NO.

8

BY AFFIDAVIT OF Funeral Director

Martin P. Hunter MEDICAL CERTIFICATION

0 0 3 1 7

**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 Lemb. 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.