

# SOUTH DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-041006

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5688

STATE FILE NUMBER

AMENDED

**FILED DEC 1 1961**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>JACKSON</u> b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u> Length of stay in 1b <u>D. O. A.</u> c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>DEAD ON ARRIVAL RESEARCH HOSPITAL</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> COUNTY <u>JACKSON</u> c. CITY OR TOWN <u>INDEPENDENCE</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>2745 SOUTH CRYSLER</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
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<b>3. NAME OF DECEASED</b> (Type or print) First <u>ROBERT</u> Middle <u>HAYNE</u> Last <u>DEISTER</u>			<b>4. DATE OF DEATH</b> Month <u>NOVEMBER</u> Day <u>11</u> Year <u>1961</u>			
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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>8/5/17</u>	9. AGE (last birthday) <u>44</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SENIOR ENGINEER</u>		11. BIRTHPLACE (City and state or country) <u>TOOL &amp; GAUGE SECT. KANSAS CITY, Mo., U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
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13a. FATHER'S NAME <u>CLARENCE W. DEISTER</u>	13b. MOTHER'S MAIDEN NAME <u>IDA MAY HAYNE</u>	14. NAME OF HUSBAND OR WIFE <u>CONNIE BURNS DEISTER</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, give war or dates of service) <u>NO</u>	17. INFORMANT <u>CONNIE BURNS DEISTER</u> Address <u>2745 S. CRYSLER INDEPENDENCE</u>
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<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> DUE TO (b) <u>Arteriosclerotic Heart disease</u> DUE TO (c) <u>Diabetes</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH
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 checked="" 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.)
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20c. TIME OF INJURY	Hour _____ a.m. _____ p.m.	Month, Day, Year	
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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 _____
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21. I attended the deceased from 1954 to Nov 11, 1961 and last saw <sup>her</sup>him alive on Nov 4, 1961  
 Death occurred at 3:30 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Don A. Black M.D.</u>	22b. ADDRESS <u>1119 24 Prof. Bldg. K.C. 6, Mo</u>	22c. DATE SIGNED <u>11/13/61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>NOV. 14, '61</u>	23c. NAME OF CEMETERY OR CREMATOR <u>MT. MORIAH CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>KANSAS CITY MISSOURI</u>
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24. FUNERAL DIRECTOR <u>D.W. NEWCOMER'S SONS</u> ADDRESS <u>1331 BRUSH CR. KANSAS CITY, MO.</u>	25. DATE RECD. BY LOCAL REG. <u>11-14-61</u>	26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED / ITEM NO. / SHOULD READ

DOCUMENT / MEDICAL CERTIFICATION / BY AFFIDAVIT OF

**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 Lenab. Michael.

Licensed Embalmer No. 4840

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.