

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-041402

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 146

Primary Registration District No. 4237

Registrar's No. 575

FILED DEC 12 1961

1. PLACE OF DEATH 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 <del>Kansas City</del> <b>Raytown</b>	Length of stay in 1b <b>7 yrs.</b>	c. CITY OR TOWN <del>Kansas City</del> <b>Raytown</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>5715 Manning</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>5715 Manning</b>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>LETTA</b> Middle <b>A.</b> Last <b>WEEKS</b>			4. DATE OF DEATH Month <b>11</b> Day <b>23</b> Year <b>61</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>7-15-1879</b>	9. AGE (last birthday) <b>82</b>	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) <b>Housekeeper</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Hotel</b>	11. BIRTHPLACE (City and state or country) <b>Fairplay, Wisconsin</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
---	---	--	---

13a. FATHER'S NAME <b>James Weeks</b>	13b. MOTHER'S MAIDEN NAME <b>Harriett Peckam</b>	14. NAME OF HUSBAND OR WIFE <b>None</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 Address <b>Mrs. J. McMurphy, K. C., 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) <b>Bacterial pneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>
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) <b>Fracture of right hip</b>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 _____ 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 **2 Dec 60** to **23 Nov 61** and last saw her live on **22 Nov 61**  
Death occurred at **5 A** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Jack M. Davis M.D.</b>	(Degree or title)	22b. ADDRESS <b>Raytown Mo</b>	22c. DATE SIGNED <b>24 Nov 61</b>
---	-------------------	-----------------------------------	--------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>11-24-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>-</b>	23d. LOCATION (City, town, or county) <b>Seneca, Kansas</b>
---	------------------------------	--	--

24. FUNERAL DIRECTOR <b>Melody-McGilley-Eylar, 1800 Linwood</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>11-24-61</b>	26. REGISTRAR'S SIGNATURE <b>Alba L. Craig</b>
--	---------	---	---

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF  
**Jack M. Davis**

ITEM NO. SHOULD READ

Prack David

9406 E. 63  
726,1000

11:00 to 5:00

Etc

### 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 Hal Rowen

Licensed Embalmer No. 3400

P. O. Address Indep., HI

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.