

# SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

6456 -61-044534  
STATE FILE NUMBER

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. \_\_\_\_\_

**FILED JAN 8 1962**

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <b>JACKSON</b>	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 lb <b>60 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>6939 CHESTNUT AVENUE</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>6939 CHESTNUT AVE.</b>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First <b>LYDIA</b>	Middle	Last <b>BURCH</b>	4. DATE OF DEATH	Month <b>DECEMBER</b>	Day <b>23</b>	Year <b>1961</b>
-------------------------------------	-----------------------	--------	----------------------	------------------	--------------------------	------------------	---------------------

5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</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>12/27/61</b>	9. AGE (last birthday) <b>68</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
-------------------------	----------------------------------	---	-------------------------------------	-------------------------------------	---------------------------	------------------------	-------	------

10a. USUAL OCCUPATION (Give kind of work done during working life, even if retired) <b>HOUSEWIFE</b>	10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (City and state or country) <b>OSAGE CITY, KANSAS</b>	12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>
---	--	---	--

13a. FATHER'S NAME <b>Unknown SKIDMORE</b>	13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	14. NAME OF HUSBAND OR WIFE <b>JOHN H. BURCH</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>JOHN H. BURCH</b>	Address <b>6939 CHESTNUT AVE. KANSAS CITY, MO.</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>2 yrs</b>
IMMEDIATE CAUSE (a) <b>Arterio-sclerotic heart disease</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) _____	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 _____ a.m. _____ p.m. _____	Month, Day, Year _____
---	---------------------------

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WRITE 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 **5/10/54** to **12/23/61** and last saw her <sup>him</sup> alive on **12/23/61**  
Death occurred at **8:50 A.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>[Signature]</i>	(Degree or title) <b>MD</b>	22b. ADDRESS <b>808 S. 15 Blue Spring mo</b>	22c. DATE SIGNED <b>12/23/61</b>
--------------------------------------	--------------------------------	---	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>Dec. 26, 1961</b>	23c. NAME OF CEMETERY (If crematory) <b>FLORAL HILLS CEMETERY</b>	23d. LOCATION (City, town, or county) <b>KANSAS CITY MISSOURI</b>
--	-----------------------------------	--	--

24. FUNERAL DIRECTOR <b>D.W. NEWCOMER'S SONS</b>	ADDRESS <b>1331 BRUSH CR KANSAS CITY, MO.</b>	25. DATE RECD. BY LOCAL REG. <b>12-26-61</b>	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>
---	--	---	---

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF  
**G. Leitch**

FORM NO. SHOULD READ

**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 Basil P. Honey

Licensed Embalmer No. 4724

P. O. Address 700 W. 1st St.

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.