

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-044670

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6361

FILED JAN 8 1962

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 <b>Kansas City</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>6222 E 10th St</b>		d. STREET ADDRESS (If outside, give location) <b>6222 E 10th St</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>VINA</b> Middle <b>FAVOURS</b> Last <b>FAVOURS</b>			4. DATE OF DEATH Month <b>December</b> Day <b>18</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>8/22/1870</b>	9. AGE (last birthday) <b>91</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>housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Vinton Iowa</b>	11. BIRTHPLACE (City and state or country) <b>Vinton Iowa</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
---	---	--	---

13a. FATHER'S NAME <b>Henry Montgomery</b>	13b. MOTHER'S MAIDEN NAME <b>Carrolyin Brainerd</b>	14. NAME OF HUSBAND OR WIFE <b>Marion Favours</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>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Marion Favours 6222 E 10th St</b>
---	--	---

18. CAUSE OF DEATH (Enter only one cause per (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3-4 months</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Generalized arteriosclerosis</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>Senility</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
--	--	--

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.) <b>Senility</b>
---	---	---

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 checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>Kansas City</b>	COUNTY <b>Jackson</b>	STATE <b>Missouri</b>
---	--	--	--------------------------	--------------------------

21. I attended the deceased from **1949** to **Dec 18-1961** and last saw her **him** alive on **Dec 18-1961**.  
Death occurred at **12 midnight** on the date stated above, and to the best of my knowledge, from the causes stated.

22. SIGNATURE <b>Stan Sulkowski</b> (Degree or title)	22b. ADDRESS <b>1601 Belmont</b>	22c. DATE SIGNED <b>12/19/61</b>
--	-------------------------------------	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>12/20/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt Moriah Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Kansas City Missouri</b>
--	------------------------------	---	--

24. FUNERAL DIRECTOR <b>Sheil Funeral Home Kansas City Mo</b>	25. DATE RECD. BY LOCAL REG. <b>12-19-61</b>	26. REGISTRAR'S SIGNATURE <b>Ruth Long</b>
--	---	---

DATE AMENDED  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 BY AFFIDAVIT OF  
 ITEM 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 Thomas A. Shiel

Licensed Embalmer No. 4954

P. O. Address J.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.