

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-045020

6347

STATE FILE NUMBER

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

LED JAN 8 1962

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 4 weeks	c. CITY OR TOWN Independence
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jackson County Hospital		Inside Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	d. STREET ADDRESS (If outside, give location) ELBIZ Sheley, <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

3. NAME OF DECEASED (Type or print) First Middle Last Henry O. Sanders			4. DATE OF DEATH Month Day Year Dec. 15 1961			
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8-24-1880	9. AGE (last birthday) 81	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done or profession, trade, or occupation, even if retired) Greenhouse		10b. KIND OF BUSINESS OR INDUSTRY Nursery		11. BIRTHPLACE (City and state or country) Hamberg, Germany		12. CITIZEN OF WHAT COUNTRY Germany

13a. FATHER'S NAME Heinrich Sanders		13b. MOTHER'S MAIDEN NAME Margarete Wunswelich		14. NAME OF HUSBAND OR WIFE Never married	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. August Bartsch, 916 W. 78th	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerosis Heart Disease</i>			INTERVAL BETWEEN ONSET AND DEATH <i>Unknown</i>
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) <i>Carcinoma of Pancreas</i>			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 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 <i>11-15-61</i> , to <i>12-15-61</i> and last saw her/him alive on <i>12-15-61</i> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE <i>J.P. McCalla, M.D.</i>		(Degree or title)		22b. ADDRESS <i>Jackson Co. Hospital</i>		22c. DATE SIGNED <i>12-17-61</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>12-18-1961</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Floral Hills, Inc.</i>		23d. LOCATION (City, town, or county) (State) <i>Kansas City, Missouri</i>	
24. FUNERAL DIRECTOR <i>Floral Hills Memorial Chapels, Inc</i> <i>Blue Ridge & Gregory</i>			ADDRESS		25. DATE RECD. BY LOCAL REG. <i>12-18-61</i>		26. REGISTRAR'S SIGNATURE <i>Ruth Long</i>

DATE AMENDED

INSTEAD OF

DOCUMENT

P. Mc Calla MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

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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 *C. M. Jones*

Licensed Embalmer No. 3453

P. O. Address H. C. Jones

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.