

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-045111

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

6545 STATE FILE NUMBER

AMENDED

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

FILED JAN 15 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 36 yr	c. CITY OR TOWN Kansas City
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3707 Highland		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 3707 Highland
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last William Arthur Wainwright			4. DATE OF DEATH Month Day Year Dec. 26 1961	
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5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3/25/92	9. AGE (last birthday) 69	IF UNDER 1 YEAR Months Days Hours Min.	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) Commercial artist	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Seneca Falls, N.Y.	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Arthur Wainwright	13b. MOTHER'S MAIDEN NAME Eva Leckie	14. NAME OF HUSBAND OR WIFE Sarah Wainwright
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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.	17. INFORMANT Mrs Sarah Wainwright T.C. 1960	Address 3707 Highland
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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 4 yr +
IMMEDIATE CAUSE (a) coronary heart disease	DUE TO (b) atherosclerosis	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	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
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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.)
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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.) On road in front of home	20f. CITY, TOWN, OR LOCATION COUNTY STATE 1 pt was dead when I saw him
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21. I attended the deceased from 1952 to present and last saw her alive on 7/25/61	Death occurred at 9:42 AM on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) Harry C. Wall MD	22b. ADDRESS 751 E 63rd	22c. DATE SIGNED 12/27/61
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23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE 12-28-1961	23c. NAME OF CEMETERY OR CREMATORY Floral Hills, Inc	23d. LOCATION (City, town, or county) (State) Kansas City Missouri
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24. FUNERAL DIRECTOR ADDRESS Floral Hills Memorial Chapels, Inc	25. DATE RECD. BY LOCAL REG. 12-28-61	26. REGISTRAR'S SIGNATURE Ruth Long
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Blue Ridge & Gregory (Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF Harry C. Wall

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 *E. M. Janner*

Licensed Embalmer No. 3450

P. O. Address R. E. Lane

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.