MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-62-001669

ARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 483 STATE FILE NUMBER

FILED FEB 13 1962

1. PLACE OF DEATH
a. COUNTY Jackson

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Jackson

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City
Length of stay in 1b: 40 Yrs.

c. CITY OR TOWN Kansas City
Inside Limits: Yes ☒ No ☐

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Forest Avenue Nursing Home
Inside Limits: Yes ☒ No ☐

d. STREET ADDRESS 2905 Forest (If outside, give location)
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First: William Middle: Last: Gaines

4. DATE OF DEATH Month 1 Day 26 Year 1962

5. SEX: Male

6. COLOR OR RACE: Negro

7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐

8. DATE OF BIRTH: Unknown

9. AGE (last birthday): About 73
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): Unknown

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (City and state or country): Unknown

12. CITIZEN OF WHAT COUNTRY: U. S. A.

13a. FATHER'S NAME: Unknown

13b. MOTHER'S MAIDEN NAME: Unknown

14. NAME OF HUSBAND OR WIFE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown): No (If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Stanley Swartz, 7606 Baltimore

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Hypostatic pneumonia

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Abdominal malignancy
DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
Senile

PART III. If deceased was female was there a pregnancy in last 90 days.
☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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 ☐ NOT WHILE AT WORK ☐

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 1-11-62, to 1-26-62 and last saw her/him alive on 1-24-62
Death occurred at 8 AM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE James E. Griffin (Degree or title) M.D.

22b. ADDRESS 3900 Paseo K.C. Mo.

22c. DATE SIGNED 1-26-62

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 1-27-62

23c. NAME OF CEMETERY OR CREMATORY: Lincoln

23d. LOCATION (City, town, or county) (State): Kansas City, Mo.

24. FUNERAL DIRECTOR ADDRESS: Jones & Stevens, 2315 Linwood Blvd.

25. DATE RECD. BY LOCAL REG.: 1-27-62

26. REGISTRAR'S SIGNATURE: Ruth Long

(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. | SHOULD READ | INSTEAD OF | DATE AMENDED

BY AFFIDAVIT OF DOCUMENT

MEDICAL CERTIFICATION

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 _____

Licensed Embalmer No. 4429

P. O. Address _____

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.