

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-001698

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 208 STATE FILE NUMBER

AMENDED

FILED JAN 25 1962

DATE AMENDED  
INSTEAD OF  
DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF  
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
ITEM NO. SHOULD READ

|   |  |   |  |  |   |  |
|---|--|---|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY Jackson  |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Missouri b. COUNTY Jackson |  |   |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN Kansas City  |  | Length of stay in 1b<br>63 YEARS  | c. CITY OR TOWN Kansas City  |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION St. Lukes Hospital   |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location)<br>4900 Holly  |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br>Wilford G GROSSE  |  |   | 4. DATE OF DEATH<br>Month Day Year<br>1 12 62  |  |   |  |
| 5. SEX<br>Male  | 6. COLOR OR RACE<br>White  | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br>9-9-98   | 9. AGE (last birthday)<br>63   | IF UNDER 1 YEAR IF UNDER 24 HR<br>Months Days Hours Min.                              |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>OWNER & OPERATOR   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br>GROSSE NURSING HOME  | 11. BIRTHPLACE (City and state or country)<br>KANSAS CITY, MO.   | 12. CITIZEN OF WHAT COUNTRY<br>U.S.A.  |   |  |
| 13a. FATHER'S NAME<br>FREDERICK HENRY GROSSE  |  | 13b. MOTHER'S MAIDEN NAME<br>NELLIE JONES   |  | 14. NAME OF HUSBAND OR WIFE<br>MRS. MARIE GROSSE   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   (If yes, give war or dates of service)<br>NO  |  | 16. SOCIAL SECURITY NO.<br>---  | 17. INFORMANT<br>Address<br>MRS. MARIE GROSSE 4900 HOLLY ST KANSAS CITY, MO.   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Overwhelming Infection</i><br><i>Toxic Myocarditis</i><br>DUE TO (b) <i>Pt. lower lobe Pneumonia</i><br>DUE TO (c) <i>Hemolytic Staphylococcus</i> |  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br>4 days<br>3 days<br>4 days                        |  |
| 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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   | 20a. ACCIDENT SUICIDE HOMICIDE<br><input type="checkbox"/> <input type="checkbox"/> <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<br>Hour a.m. p.m.<br>Month, Day, Year   |  |   |  |  |   |  |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/><br>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 1940 to 1-12-62 and last saw him live on 1-11-62<br>Death occurred at 4:15 A m on the date stated above, and to the best of my knowledge, from the causes stated.  |  |   |  |  |   |  |
| 22a. SIGNATURE (Degree or title)<br>Harold M. Roberts, M.D.   |  |   | 22b. ADDRESS<br>1193 Grand K.C. 6 Mo.  |  | 22c. DATE SIGNED<br>1-12-62   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>BURIAL   | 23b. DATE<br>JAN. 13, 1962   | 23c. NAME OF CEMETERY OR CREMATORY<br>MEMORIAL PARK CEMETERY KANSAS CITY MISSOURI   |  | 23d. LOCATION (City, town, or county) (State)  |   |  |
| 24. FUNERAL DIRECTOR<br>D.W. NEWCOMER'S SONS KANSAS CITY, MO.   | ADDRESS<br>1351 BRUSH CR.  | 25. DATE RECD. BY LOCAL REG.<br>1-13-62   | 26. REGISTRAR'S SIGNATURE<br>Ruth Long   |  |   |  |

**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 Norman W. Larson

Licensed Embalmer No. 4089

P. O. Address Lathrop, 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.