

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-002097

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

561

STATE FILE NUMBER

AMENDED

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

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>		Length of stay in 1b <b>17 YEARS</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>2911 EAST 67th STREET</b>			d. STREET ADDRESS (If outside, give location) <b>2911 EAST 67th STREET</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>ANN</b> Last <b>WALL</b>			4. DATE OF DEATH Month <b>JANUARY</b> Day <b>28th</b> Year <b>1962</b>		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>CAUCASIAN</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>11-5-78</b>	9. AGE (last birthday) <b>83</b>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____
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>DOMESTIC</b>		11. BIRTHPLACE (City and state or country) <b>WALES</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13a. FATHER'S NAME <b>THOMAS</b>		13b. MOTHER'S MAIDEN NAME <b>MARGARET MORGAN</b>		14. NAME OF HUSBAND <b>CHRIS. C. WALL</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>KANSAS CITY, MISSOURI</b> <b>MRS. C.A. STROCK, 2911 EAST 67th ST.</b>	
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 <b>?</b>
IMMEDIATE CAUSE (a) <b>Pneumonia</b>					
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					
DUE TO (b) <b>Age -</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)				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.)			
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 <b>1961</b> to _____ and last saw her/him alive on <b>1-29-62</b> Death occurred at <b>11.55. P</b> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>George V Feisk MD</b> (Degree or title)			22b. ADDRESS <b>11797 Professional Bldg</b>		22c. DATE SIGNED <b>1-29-62</b>
23a. BURIAL, CREMATION, or OTHER (Specify) <b>BURIAL</b>	23b. DATE <b>JAN. 31, 1962</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>MEMORIAL PARK CEMETERY KANSAS CITY</b>		23d. LOCATION (City, town, or county) (State) <b>KANSAS</b>	
24. FUNERAL DIRECTOR <b>B.W. Newcomer's Sons, Kansas City, Mo</b>		25. DATE RECD. BY LOCAL REG. <b>1-30-62</b>		26. REGISTRAR'S SIGNATURE <b>Ruth H Long</b>	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
DATE AMENDED  
INSTEAD OF  
SHOULD READ  
ITEM NO.

DOCUMENT  
BY AFFIDAVIT OF  
GEORGE V. FEISK 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 Vern Lawler

Licensed Embalmer No. 4915

P. O. Address K.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.