

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

163-028269
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4052

FILED AUG 6 1963	
<p>1. PLACE OF DEATH</p> <p>a. COUNTY JACKSON</p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY Length of stay in 1b 9 MOS.</p> <p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION SOUTHWOOD GERIATRIC CENTER Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE MISSOURI COUNTY JACKSON</p> <p>c. CITY OR TOWN KANSAS CITY Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) 912 LOCUST Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>
<p>3. NAME OF DECEASED (Type or print) First RUTH Middle EDER Last</p>	<p>4. DATE OF DEATH Month JULY Day 19 Year 1963</p>
<p>5. SEX F</p>	<p>6. COLOR OR RACE W</p>
<p>7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/></p>	<p>8. DATE OF BIRTH 10-17-1879</p>
<p>9. AGE (last birthday) 83</p>	<p>IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/></p>
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE</p>	<p>10b. KIND OF BUSINESS OR INDUSTRY HOME</p>
<p>11. BIRTHPLACE (City and state or country) IOWA</p>	<p>12. CITIZEN OF WHAT COUNTRY USA</p>
<p>13a. FATHER'S NAME SCHUBEL SHATTUCK</p>	<p>13b. MOTHER'S MAIDEN NAME ABBIE JANE COOK</p>
<p>14. NAME OF HUSBAND OR WIFE FRED EDER</p>	<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service.) NO</p>
<p>16. SOCIAL SECURITY NO. <input type="checkbox"/></p>	<p>17. INFORMANT Address MRS. JACK SALYERS LENEXA, KS.</p>
<p>18. CAUSE OF DEATH (Enter only one cause per line)</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p style="text-align: center;">IMMEDIATE CAUSE (a) CEREBRAL HEMMORRHAGE</p> <p style="text-align: center;">DUE TO (b) Arteriosclerosis</p> <p style="text-align: center;">DUE TO (c)</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)</p>	
<p>INTERVAL BETWEEN ONSET AND DEATH 1 day</p> <p>10 years</p>	
<p>PART III. If deceased was female was there a pregnancy in last 90 days.</p> <p style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>	
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></p>	<p>20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/></p>
<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)</p>	
<p>20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. Month, Day, Year</p>	<p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p>
<p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>20f. CITY, TOWN, OR LOCATION COUNTY STATE</p>	
<p>21. I attended the deceased from 7-17-63 to 7-19-63 and last saw her/him alive on 7-19-63</p> <p>Death occurred at 1:25 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.</p>	
<p>22. SIGNATURE (Degree or title) Frank Lawrence M.D.</p>	<p>22b. ADDRESS 428 S White Ave</p>
<p>22c. DATE SIGNED 7-19-63</p>	
<p>23a. BURIAL, CREMATION, REMOVAL REMOVAL</p>	<p>23b. DATE 7-19-1963</p>
<p>23c. NAME OF CEMETERY OR CREMATORY MC CUNE CEMETERY</p>	<p>23d. LOCATION (City, town, or county) (State) MC CUNE, KANSAS</p>
<p>24. FUNERAL DIRECTOR ADDRESS EUGENE P. AMOS SHAWNEE, KANSAS</p>	<p>25. DATE RECD. BY LOCAL REG. 7-20-63</p>
<p>26. REGISTRAR'S SIGNATURE Ruth Long</p>	

DO NOT WRITE ON THIS STUB

AMENDED

VS 300	DATE AMENDED
Rev. 4/59	
1	
23/38	
3	
4 1	
5 2	
6	
7 1	
8 0	
9331X	
10	
11	
12 86-0	
13	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Frank Lawrence M.D.

USE BLACK INK OR TYPEWRITER RIBBON

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 *Eugene P. Amos*
EUGENE P. AMOS
Licensed Embalmer No. 5023

P. O. Address SHAWNEE, KANSAS

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.