

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-036207

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4768

4768

FILED SEP 16 1963

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

INSTEAD OF

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

BY AFFIDAVIT OF

Frank Paul Laurencz, M.D. MEDICAL CERTIFICATION

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Jackson</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) e. STATE <u>Kansas</u> b. COUNTY <u>Wyandotte</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u> | | Length of stay in 1b <u>3 yrs</u> | c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>3200 Norledge</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>1618 New Jersey</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>IRA</u> Middle <u>A.</u> Last <u>HOBBS</u> | | 4. DATE OF DEATH Month <u>August</u> Day <u>28</u> Year <u>1963</u> | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>8/24/1876</u> |
| 9. AGE (last birthday) <u>87 yrs</u> | | 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) <u>Building Contractor</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home Building</u> | 11. BIRTHPLACE (City and state or country) <u>Missouri</u> |
| 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | | 13a. FATHER'S NAME <u>James Hobbs</u> | |
| 13b. MOTHER'S MAIDEN NAME <u>Laura Brown</u> | | 14. NAME OF HUSBAND OR WIFE <u>Iela Hobbs</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <u>no none</u> | | 16. SOCIAL SECURITY NO. <u>1</u> | 17. INFORMANT <u>Vera Kerns</u> Address <u>1618 New Jersey Kansas City, Kansas</u> |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA</u> DUE TO (b) <u>Chronic Myocarditis</u> DUE TO (c) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>7 years</u> <u>12 years</u> |
| 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 checked="" 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 <u>7-3-60</u> and last saw her/him alive on <u>8-28-63</u> Death occurred at <u>145 AM</u> of the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <u>Frank Paul Laurencz, M.D.</u> | | 22b. ADDRESS <u>428 S. White Ave</u> | 22c. DATE SIGNED <u>8-28-63</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>8/30/1963</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope Cemetery</u> | 23d. LOCATION (City, town, or county) <u>Kansas City, Kansas</u> |
| 24. FUNERAL DIRECTOR <u>R.A. Fulton</u> ADDRESS <u>K.C., Kansas</u> | | 25. DATE RECD. BY LOCAL REG. <u>8-28-63</u> | 26. REGISTRAR'S SIGNATURE <u>Bessie Smith</u> |

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 Eddie H. Juekel

Licensed Embalmer No. 5744

P. O. Address H. C. Kaus

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.

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