

STANDARD CERTIFICATE OF DEATH

BIRTH NO. REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 181

|   |                               |   |   |
|---|-------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>JACKSON</u><br><u>TRINITY LUTHERAN HOSP</u>   |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Missouri</u> b. COUNTY <u>JACKSON</u> |   |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>KANSAS CITY, MO</u>   |                               | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>KANSAS CITY</u>   |   |
| c. LENGTH OF STAY (in this place) <u>20 yrs</u>   |                               | d. STREET ADDRESS (If rural, give location) <u>623 Euclid</u>   |   |
| d. FULL NAME OF (If not in hospital or institution, give street address or location), HOSPITAL OR INSTITUTION <u>TRINITY LUTHERAN HOSP.</u>   |                               |   |   |
| 3. NAME OF DECEASED<br>(Type or Print) a. (First) <u>AMADA</u> b. (Middle) <u>ELMIRA</u> c. (Last) <u>Sutcliffe</u>   |                               | 4. DATE OF DEATH (Month) (Day) (Year) <u>1-12-49</u>  |   |
| 5. SEX <u>FEMALE</u>  | 6. COLOR OR RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOW</u>   | 8. DATE OF BIRTH <u>1-11-1861</u>                     |
| 9. AGE (In years last birthday) <u>88</u>   |                               | 10. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <u>Housewife</u>                                      | 11. BIRTHPLACE (State or foreign country) <u>Iowa</u> |
| 10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired)  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>   | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>            |
| 13a. FATHER'S NAME <u>Joseph Ross</u>   |                               | 13b. MOTHER'S MAIDEN NAME <u>MARY BARR</u>  |   |
| 14. NAME OF HUSBAND OR WIFE <u>Joseph Blackwell</u>   |                               |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>  |                               | 16. SOCIAL SECURITY NO. <u>none</u>   |   |
| 17. INFORMANT'S SIGNATURE OR NAME <u>Joseph Mrs. C.E. Brown</u>   |                               | ADDRESS <u>623 Euclid</u>   |   |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.                 |                               |   |   |
| MEDICAL CERTIFICATION   |                               |   |   |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocardial failure</u>  |                               | INTERVAL BETWEEN ONSET AND DEATH <u>1/9/49</u>  |   |
| ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause. (a) stating the underlying cause last.<br>DUE TO (b) <u>Old age</u>   |                               |   |   |
| DUE TO (c) <u>Coronary Renal disease</u>  |                               |   |   |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.   |                               |   |   |
| 19a. DATE OF OPERATION  |                               | 19b. MAJOR FINDINGS OF OPERATION <u>442</u>   |   |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                               |   |   |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify)  |                               | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |   |
| 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)   |                               |   |   |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)   |                               | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                      |   |
| 21f. HOW DID INJURY OCCUR? <u>0</u>   |                               |   |   |
| 22. I hereby certify that I attended the deceased from <u>1945</u> to <u>Jan 12 1949</u> that I last saw the deceased alive on <u>Jan 12, 1949</u> , and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above. |                               |   |   |
| 23a. SIGNATURE <u>J. J. Farnsworth</u> (Degree or title) <u>J. J. Farnsworth M.D.</u>   |                               | 23b. ADDRESS <u>110.3 Grand Ave. Mo.</u>  |   |
| 23c. DATE SIGNED <u>1/13/49</u>   |                               |   |   |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>   |                               | 24b. DATE <u>1-14-49</u>  |   |
| 24c. NAME OF CEMETERY OR CREMATORY <u>Forest Hill Cemetery</u>  |                               | 24d. LOCATION (City, town, or county) (State) <u>KANSAS CITY, MO</u>  |   |
| DATE REC'D BY LOCAL REG. <u>1-14-49</u>   |                               | REGISTRAR'S SIGNATURE <u>Sheraldine Holmes</u>  |   |
| 25. FUNERAL DIRECTOR'S SIGNATURE <u>C. H. Blackwell Son</u>   |                               | ADDRESS <u>Kansas City, Mo</u>  |   |

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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

*JAMES W. WAIR*

Student Embalmer No. *98*

working under my personal supervision.

Student *James W. Wair*  
Student Embalmer

Signed

*O. K. McFarland*

Licensed Embalmer No. *4397*

P. O. Address *Kansas City*

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 this body is not embalmed, fact should be so stated above.