

Public Health Service

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 1065
 REGISTRATION DISTRICT NO. 149
 PRIMARY REGISTRATION DISTRICT NO. 1001
 REGISTRAR'S NO. 2773

FILED JUN 28 1957

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson			
b. CITY (If outside corporate limits, give TOWNSHIP only) Kansas City			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kansas City			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Gen'l Hosp. #1		Length of stay in lb 37 YEARS		d. STREET ADDRESS (If outside, give location) 5705 Jackson			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Dorothy Middle Louise Last Frey				4. DATE OF DEATH Month 6 Day 10 Year 1957			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 17 1920		9. AGE (In years last birthday) 37	IF UNDER 1 YEAR Months 3 Days 7
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (City and state or country) KANSAS CITY MISSOURI		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13a. FATHER'S NAME WILLIE ORVAL WILLIAMSON			13b. MOTHER'S MAIDEN NAME MAGGIE COX		14. NAME OF HUSBAND OR WIFE JOSEPH M. FREY		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. NONE	17. INFORMANT JOSEPH M. FREY		Address 5705 JACKSON AVENUE KANSAS CITY MISSOURI	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive intracerebral hemorrhage							INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Hypertensive crises with encephalopathy							
DUE TO (c) _____							331X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a).							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.							
20d. INJURY OCCURRED WHILE AT <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 June 10, 1957 to June 10, 1957 and last saw her ^{her} alive on June 10, 1957 Death occurred at 1:20 P. m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <i>W. I. Burns, M.D.</i> (Degree or title)				22b. ADDRESS 24th & Cherry		22c. DATE SIGNED 6-11-57	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE JUNE 13 1957	23c. NAME OF CEMETERY OR CREMATORY MEMORIAL PARK CEMETERY		23d. LOCATION (City, town, or county) (State) KANSAS CITY MISSOURI		
24. FUNERAL DIRECTOR D.W. NEWCOMER'S SONS			ADDRESS 1331 BRUSH CREEK KANSAS CITY, MO.	25. DATE RECD. BY LOCAL REG. 6-13-57		26. REGISTRAR'S SIGNATURE <i>Heva Marshall</i>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
 MEDICAL CERTIFICATION
 B. I. Burns

All diseases in Part I must be causally related.

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

Basil Honey

Licensed Embalmer No. *4724*

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.