

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-044169

STATE FILE NUMBER 5749

FILED DEC 30 1958

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

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
Royall B. Fleming

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|---|--|---|--------------------------------|---|-------------------------------|--|---|---|--|-------|
| 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) OR TOWN 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 QUEEN OF THE WORLD HOSPITAL | | | Length of stay in lb 46 yrs | | d. STREET ADDRESS 2632 EUCLID | | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last JOHN HILL | | | | 4. DATE OF DEATH Month Day Year NOVEMBER 30, 1958 | | | | | | |
| 5. SEX MALE | | 6. COLOR OR RACE NEGRO | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH July 30th 1890 | | 9. AGE (In years last birthday) 68 | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired | | 10b. KIND OF BUSINESS OR INDUSTRY realestate | | 11. BIRTHPLACE (City and state or country) MISSOURI | | 12. CITIZEN OF WHAT COUNTRY? U S A | | | | |
| 13. FATHER'S NAME John Hill | | | | 14. MOTHER'S MAIDEN NAME Lottie Powell | | | | | | |
| 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 Address ARZELIA WALLS, SISTER 2632 Euclid KCMO | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHIAL PNEUMONIA, BILATERAL | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | DUE TO (b) | | DUE TO (c) | | 4914 B | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Central nervous system lues; cerebral arteriosclerosis; focal areas of encephalomalacia. | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 Month, Day, Year a. m. p. m. | | 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 11-28-58 to 11-30-58 and last saw her alive on 11-30-58 Death occurred at 1:30 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | | | | |
| 22a. SIGNATURE Royce D. Fleming, M.D. | | | | 22b. ADDRESS 1433 E-19th St | | | | 22c. DATE SIGNED 12-1-58 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION | | 23b. DATE 12-5-58 | | 23c. NAME OF CEMETERY OR CREMATORY Elmwood Crematory | | 23d. LOCATION (City, town, or county) Kansas City, Mo. | | (State) | | |
| 24. FUNERAL DIRECTOR A DKINS FUNERAL HOME Kansas City, Mo. | | | | 25. DATE RECD. BY LOCAL REG. 12-5-58 | | 26. REGISTRAR'S SIGNATURE neva minshall | | | | |



March 1951

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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.....
[Handwritten Signature]

Licensed Embalmer No.

P. O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.