Health, Welfare Public Service

300
1-57

FILED FEB 27 1959

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-005684
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 721

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 4105 E. 14th Terr. — Length of stay in lb 50 yrs.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY Jackson
c. CITY OR TOWN Kansas City — Inside Limits Yes [ ] No [ ]
d. STREET ADDRESS (If outside, give location) 4105 E. 14th Terr. — Reside on Farm Yes [ ] No [ ]

3. NAME OF DECEASED (Type or print) First Amanda Middle Last Larkins

4. DATE OF DEATH Month Feb. Day 2 Year 59

5. SEX Female

6. COLOR OR RACE Negro

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH Sept. 14 1881

9. AGE (In years last birthday) 77 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country) Missouri

12. CITIZEN OF WHAT COUNTRY? U. S.

13a. FATHER'S NAME John Larkins

13b. MOTHER'S MAIDEN NAME Elizabeth —

14. NAME OF HUSBAND OR WIFE None

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 Corrine Morgan Address 4105 E. 14th Te

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Decompensation — INTERVAL BETWEEN ONSET AND DEATH 2 WKS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerotic Heart Disease
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Fibroids Uterus.

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X] 2

20a. ACCIDENT [ ] **SUICIDE** [ ] **HOMICIDE** [ ]

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 [ ] NOT WHILE AT WORK [ ]

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 11/18/58, to 2/2/59 and last saw her alive on 2/1/59
Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) J S Johnson MD

22b. ADDRESS 202 E 18th

22c. DATE SIGNED 2-6-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE 2-7-59

23c. NAME OF CEMETERY OR CREMATORY Blue Ridge Lawn

23d. LOCATION (City, town, or county) (State) Kansas City, Mo.

24. FUNERAL DIRECTOR ADDRESS Manlove-Williams 1729 Lydia

25. DATE RECD. BY LOCAL REG. 2-7-59

26. REGISTRAR'S SIGNATURE Neva Marshall

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.

J. S. Johnson

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 D. J. Manlove

Licensed Embalmer No. 3994

P. O. Address 3712 E 30th

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.