

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-005698
STATE FILE NUMBER
617

FILED FEB 19 1959 Administration District No. 149 Primary Registration District No. 1602 Registrar's No.

300
1-57

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
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION General Hosp		Length of stay in 1b 40 Yrs	d. STREET ADDRESS (If outside, give location) 454 Tracy
3. NAME OF DECEASED (Type or print) First WILLIAM Middle H Last LINVILLE			4. DATE OF DEATH Month 2 Day 1 Year 1959
5. SEX M	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1 11 1878.
10a. USUAL OCCUPATION (Give kind of work done during at least working life, even if retired) Ret. Hoisting Engr.		10b. KIND OF BUSINESS OR INDUSTRY Engineering	11. BIRTHPLACE (City and state or country) Heradsburg, Kentucky
12. CITIZEN OF WHAT COUNTRY? U. S. A		13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown
14. NAME OF HUSBAND OR WIFE Hattie S. Linville		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war and dates of service) No	16. SOCIAL SECURITY NO. 495 09 4236
17. INFORMANT Mrs. Hattie S. Linville		Address 454 Tracy	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion			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) _____			
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 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 _____ to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Hugh H. Owens (Degree or title)		22b. ADDRESS 1034 Prairie Blvd	22c. DATE SIGNED 2-2-59
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
Burial	2-3-59	Floral Hills	Kansas City Missouri
24. FUNERAL DIRECTOR Floral Hills Memorial Chapels, Inc		25. DATE RECD. BY LOCAL REG. 2-2-59	26. REGISTRAR'S SIGNATURE Reva Marshall

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Hugh H. Owens

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 Forrest D. Coldman

Licensed Embalmer No. 4714

P. O. Address K. E. 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.