ealth, Welfare ublic ervice

300
-57 0

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-009306
STATE FILE NUMBER

FILED MAR 26 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1289

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY OR TOWN Kansas City — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) General Hospital #2 — Length of stay in 1b 35 yrs

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Jackson
c. CITY OR TOWN Kansas City — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location) 1417 E. 17th St. — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First: H oward Middle: Last: Buckingham
4. DATE OF DEATH Month March Day 6 Year 1959
5. SEX Male
6. COLOR OR RACE Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH Oct 5 1907
9. AGE (In years last birthday) 51 — 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) Laborer
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) Texas
12. CITIZEN OF WHAT COUNTRY? U S A
13a. FATHER'S NAME San Buckingham
13b. MOTHER'S MAIDEN NAME Mary
14. NAME OF HUSBAND OR WIFE unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 490-16-7043
17. INFORMANT Phillip McKinney Address 1327 Lydia

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Thrombosis
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)
Old Tuberculosis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

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 3-4-49 to 3-6-59 and last saw her/him alive on 3-6-59
Death occurred at 12:05 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) [signature]
22b. ADDRESS 600 East 22nd Street
22c. DATE SIGNED 3-11-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 3/14/59
23c. NAME OF CEMETERY OR CREMATORY Blue Ridge Lawn
23d. LOCATION (City, town, or county) Kansas City (State) Mo

24. FUNERAL DIRECTOR Manlove-Williams ADDRESS 1729 Lydia
25. DATE RECD. BY LOCAL REG. 3-11-59
26. REGISTRAR'S SIGNATURE Neva Marshall

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

E. Frank Ellis

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 Maynard C. Wallace

Licensed Embalmer No. 4653

P. O. Address 96 C

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.