

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-009500

STATE FILE NUMBER
1313

FILED MAR 26 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1313

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 name) HOSPITAL OR INSTITUTION 3001 Woodland		Length of stay in lb 36 yrs.	d. STREET ADDRESS (If outside, give location) 2500 E. 33rd St.
3. NAME OF DECEASED (Type or print) First MIDDLE Last FLAVE LEE KIDD			4. DATE OF DEATH Month Day Year March 10, 1959
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 8, 1890
9. AGE (In years last birthday) 68 yrs.		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) Farmer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Henry County, Missouri
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Henry Kidd	
13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE	
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 Ellen Carroll 3033 Brooklyn Niece
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism DUE TO (b) Gangrene Bath feet DUE TO (c) Generalized arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Cerebral Vascular Accident			INTERVAL BETWEEN ONSET AND DEATH 4 hrs 1 wk !
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.) 331X	
20c. TIME OF INJURY Hour Month, Day, Year 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 Death occurred at 8 pm Feb 29 1959 to 10 am 59 and last saw him alive on 9 March 59 on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) John H. Wells MD		22b. ADDRESS 4011 Fenwood Blvd	
22c. DATE SIGNED 11 March 59		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE 3-16-59		23c. NAME OF CEMETERY OR CREMATORY Lincoln	
23d. LOCATION (City, town, or county) Kans. City, Missouri		23e. (State)	
24. FUNERAL DIRECTOR Watkins Bros. Funeral Home 18th & Bentpn		25. DATE RECD. BY LOCAL REG. 3-12-59	
26. REGISTRAR'S SIGNATURE Neva Marshall			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

John H. Wells

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 *Diana P. Watkins*

Licensed Embalmer No. *4500*

P. O. Address *18th & Benton*

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.