

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-013294

STATE FILE NUMBER

1986

DECEASED MAY 13 1959

Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

300
1-57

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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		c. CITY OR TOWN KANSAS CITY	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2114 Wabash		d. STREET ADDRESS (If outside, give location) 2114 Wabash	
3. NAME OF DECEASED (Type or print) First CHARLES Middle KEITH Last FRIENDS		4. DATE OF DEATH Month Day Year April 18, 1959	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 26, 1959
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 1 IF UNDER 1 YEAR Months Days Hours Min. 22
11. BIRTHPLACE (City and state or country) Kans. City, Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME Gloria Friends	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. -	17. INFORMANT Address Gloria Friends 2114 Wabash
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-Pneumonia 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) Hypertrophied Thyroid Gland-malnutrition			INTERVAL BETWEEN ONSET AND DEATH 491X
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 <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 L. M. Tillman		22b. ADDRESS 1618 Lydia Ave	22c. DATE SIGNED 4/21/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4-24-59	23c. NAME OF CEMETERY OR CREMATORY Blue Ridge Lawn	23d. LOCATION (City, town, or county) Kans. City, Missouri
24. FUNERAL DIRECTOR ADDRESS Watkins Bros. Funeral Home 18th & Benton		25. DATE RECD. BY LOCAL REG. 4-21-59	26. REGISTRAR'S SIGNATURE neva minshall

L. M. Tillman



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 *Benjamin 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.