

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-013362

STATE FILE NUMBER

FILED APR 27 1959

Registration District No. 149

Primary Registration District No. 002

Registrar's No. 1775

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		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3032 GARFIELD AVE.			Length of stay in 1b 59 YEARS		d. STREET ADDRESS 3032 GARFIELD AVENUE		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last ADA M. JENKINS				4. DATE OF DEATH Month Day Year APRIL 5, 1959					
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 25, 1874		c. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY --	11. BIRTHPLACE (City and state or country) WELLSBURG, WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13a. FATHER'S NAME ALBERT WHEELER KUHN			13b. MOTHER'S MAIDEN NAME MATTIE HOOKER		14. NAME OF HUSBAND or WIFE JOHN C. JENKINS				
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 JOHN C. JENKINS				3032 GARFIELD AVENUE KANSAS CITY, MISSOURI	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congested heart failure mitral insufficiency of chronic nature Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 2 months		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 410 X							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 Month, Day, Year a.m. p.m.									
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 5/13/1959 to 4/14/1959 and last saw her alive on 4/14/1959 Death occurred at 4:00 P. m. on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) James T. Ferguson M.D.				22b. ADDRESS 410 Bryant Rd. Kansas City			22c. DATE SIGNED 4/16/59		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE APRIL 7, 1959	23c. NAME OF CEMETERY MT. WASHINGTON CEMETERY		23d. LOCATION (City, town, or county) KANSAS CITY		MISSOURI		
24. FUNERAL DIRECTOR 1331 BRUSH CREEK BLVD. D. W. NEWCOMER'S SONS-K. C., MO.				25. DATE RECD. BY LOCAL REG. 4-7-59		26. REGISTRAR'S SIGNATURE Irene Marshall			

James T. Ferguson USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

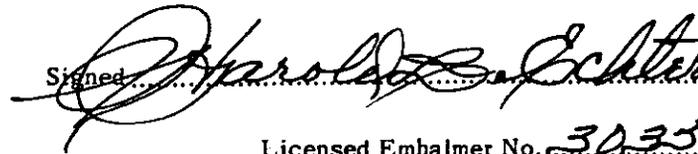
MEDICAL CERTIFICATION

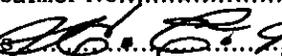
All diseases in Part I must be causally related.

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 

Licensed Embalmer No. 3035
P. O. Address 

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.