

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024708

FILED VS JUL 21 1959

Registration District No. 20 Primary Registration District No. _____ Registrar's No. 65

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>GENTRY</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ALBANY</u> Length of stay in 1b <u>1 wk.</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>GENTRY Co. MEM. Hosp</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>KANSAS</u> b. COUNTY <u>SEDGWICK</u> c. CITY OR TOWN <u>WICHITA</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>813 MAPLE</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>PERRY</u> Middle <u>JEFFERSON</u> Last <u>HITT</u>			4. DATE OF DEATH Month <u>JULY</u> Day <u>8</u> Year <u>1959</u>				
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 13 - 1884</u>	9. AGE (last birthday) <u>88</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>		11. BIRTHPLACE (City and state or country) <u>MT. PLEASANT, IOWA</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>UNKNOWN</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		14. NAME OF HUSBAND OR WIFE <u>CALLIE HITT</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>EARL HITT</u> Address <u>813 MAPLE WICHITA, KAS.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemiplegia rt.</u> DUE TO (b) <u>arteriosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>8 days.</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
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. Month, Day, Year _____		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 <u>Albany</u>		COUNTY <u>Gentry</u> STATE <u>MO.</u>			
21. I attended the deceased from <u>7-1-59</u> to <u>7-8-59</u> and last saw him alive on <u>7-8-59</u> Death occurred at <u>12:50 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Frank H. Ross, M.D.</u> (Degree or title)			22b. ADDRESS <u>Albany, Mo</u>		22c. DATE SIGNED <u>7-9-59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>7-10-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ROUSE</u>		23d. LOCATION (City, town, or county) (State) <u>DARLINGTON, MO.</u>		
24. FUNERAL DIRECTOR <u>JOHNSON F.H. STANBERRY, MO.</u> ADDRESS _____			25. DATE RECD. BY LOCAL REG. <u>7-13-59</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. L.W. Bare</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Robert E. Johnson*

Licensed Embalmer No. 4948

P. O. Address Stanley

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do 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.