

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-025067

FILED JUL 17 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3309 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u>		c. CITY OR TOWN <u>KANSAS CITY</u>	
Length of stay in 1b <u>46 YEARS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>2930 Charlotte</u>		d. STREET ADDRESS (If outside, give location) <u>2930 CHARLOTTE</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>DOLPHINE</u> Middle <u>CURRY</u> Last <u>CURRY</u>			4. DATE OF DEATH Month <u>JULY</u> Day <u>5</u> Year <u>1959</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>CAUC</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>Jan 7 1887</u>	9. AGE (last birthday) <u>72</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (City and state or country) <u>KEWANEE, ILL.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>AXEL BURKLUND</u>		13b. MOTHER'S MAIDEN NAME <u>ANNA ANDERSON</u>		14. NAME OF HUSBAND OR WIFE <u>Chas. R. CURRY</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>NONE</u>		17. INFORMANT <u>CHARLES R. CURRY, 2930 CHARLOTTE</u>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u>		<u>Immediate</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Ch. Hypertensive Cardio-Vascular Disease</u>	<u>Over 10yr</u>
	DUE TO (c) _____	

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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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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	COUNTY	STATE
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21. I attended the deceased from 1919 to July 5 1959 and last saw her alive on July 5-1959
Death occurred at 9:40 PM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Glenn H. Troyles M.D.</u>	22b. ADDRESS <u>1232 Professional Bldg</u>	22c. DATE SIGNED <u>7-7-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>JULY 8, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MEMORIAL PARK</u>	23d. LOCATION (City, town, or county) (State) <u>KANSAS CITY MO.</u>
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24. FUNERAL DIRECTOR <u>MUEHLEBACH</u>	ADDRESS <u>6800 TROOST</u>	25. DATE RECD. BY LOCAL REG. <u>7-7-59</u>	26. REGISTRAR'S SIGNATURE <u>neva minshall</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Glenn H. Troyles

DR Broyles
Prof Bldg
BA 1-4420

11-4

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

↓
Warren R Ellis

Licensed Embalmer No. 5018

P. O. Address Mission K

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.