

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-025190

FILED VS AUG 10 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3547

STATE FILE NUMBER

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	
Length of stay in lb 40 YRS.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3741 AGNES		d. STREET ADDRESS (If outside, give location) 3741 AGNES	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last CHARLES HENRY HITCHBORN			4. DATE OF DEATH Month Day Year JULY 19, 1959			
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5. SEX MALE	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 AUG 7, 1868	9. AGE (last birthday) 90 YRS.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED NEWS PAPER EDITOR DAILY DROVER'S	10b. KIND OF BUSINESS OR INDUSTRY TELEGRAM	11. BIRTHPLACE (City and state or country) JEFFERSONVILLE, ILL	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME WILLIAM ALONZO HITCHBORN	13b. MOTHER'S MAIDEN NAME MARY ELLEN BOYKIN	14. NAME OF HUSBAND OR WIFE MALISSA ELLEN HITCHBORN
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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. 33212 0243A	17. INFORMANT 2001 IND. AVE. K. C. MO. WILBER A. HITCHBORN
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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) DUODENAL ULCER PERFERATED		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) CHRONIC DUADENAL ULCER	
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 type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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.)
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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 1949 to JULY 19, 1959 and last saw her/him alive on July 19, 1959	
Death occurred at 7:20 A. m on the date stated above, and to the best of my knowledge, from the causes stated.	

22a. SIGNATURE (Degree or title) James J Ferguson	22b. ADDRESS 410 Bryant St	22c. DATE SIGNED 7-20-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE JULY 21, 1959	23c. NAME OF CEMETERY OR CREMATORY MT. WASHINGTON CEM	23d. LOCATION (City, town, or county) (State) KANSAS CITY, MO.
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24. FUNERAL DIRECTOR D. W. NEWCOMER'S SONS K. C. MO.	25. DATE RECD. BY LOCAL REG. 7-26-59	26. REGISTRAR'S SIGNATURE Neva Minshall
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DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF James J. Ferguson

**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 Albert L. Savage

Licensed Embalmer No. 4812

P. O. Address Kansas City, Mo.

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