

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-025205

FILED VS AUG 14 1959/49

Registration District No. 1002 Primary Registration District No. 1002 Registrar's No. 3739 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		Length of stay in 1b 46 Yrs	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 Neurological Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 506 Newton Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last AMOS EARL HUFF			4. DATE OF DEATH Month Day Year August 1 1959 1959		
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 8/29/1895	9. AGE (last birthday) 63	IF UNDER 1 YEAR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Crane Operator	10b. KIND OF BUSINESS OR INDUSTRY Sheffield Steel	11. BIRTHPLACE (City and state or country) Selma Kansas	12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME Barnard Huff	13b. MOTHER'S MAIDEN NAME Alta DeFore	14. NAME OF HUSBAND OR WIFE Minnie Huff	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WW I	16. SOCIAL SECURITY NO. 487-05-5354	17. INFORMANT Address Mrs Minnie Huff 506 Newton N C Mo
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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) CEREBRAL THROMBOSIS		-6 HOURS
Conditions, if any, which gave rise to above cause (a), starting the underlying cause last.	DUE TO (b) CEREBRAL ARTERIOSCLEROSIS	10+ YEARS
	DUE TO DIABETES MELLITUS	1+ YEARS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Chronic Brain Syndrome associated with CEREBRAL ARTERIOSCLEROSIS		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 Month, Day, Year a.m. p.m.	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

21. I attended the deceased from **JULY 9, 1959** to **AUG 1, 1959** and last saw ^{her} alive on **AUG 1, 1959**
Death occurred at **5:05 A** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Albert E. Fulton M.D.	22b. ADDRESS 2625 W. PASEO KANSAS CITY MO	22c. DATE SIGNED 8-1-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Aug 3 1959	23c. NAME OF CEMETERY OR CREMATORY Floral Hills Cemetery
24. FUNERAL DIRECTOR ADDRESS Sheil Funeral Home Kansas City Mo	23d. LOCATION (City, town, or county) (State) Kansas City Mo	25. DATE RECD. BY LOCAL REG. 8-3-59
		26. REGISTRAR'S SIGNATURE Ilva Minichall

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF **Albert E. Fulton**

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 Richard E. Carroll

Licensed Embalmer No. 4829

P. O. Address R. E. 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.