

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-025359

FILED 15 AUG 14 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3753 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 lb 93 days	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 4121 TRACY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4121 TRACY Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First SUSAN Middle E Last POLLEY			4. DATE OF DEATH Month AUG. Day 2, Year 1959			
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH JUN 28, 1866	9. AGE (last birthday) 93	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) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY PLATTE COUNTY MISSOURI	11. BIRTHPLACE (City and state or country) U.S.A.	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME JOHN H. JONES	13b. MOTHER'S MAIDEN NAME KATHERINE ARTMAN	14. NAME OF HUSBAND OR WIFE (DECEASED) WILLIS G. POLLEY
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) NO	16. SOCIAL SECURITY NO. NO	17. INFORMANT JOHN W. POLLEY 4121 TRACY	Address
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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: IMMEDIATE CAUSE (a) Spandized cardiac sclerosis		INTERVAL BETWEEN ONSET AND DEATH —
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	
	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 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.)
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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 June 1954 to Aug 2, 1959 and last saw her live on July 30, 1959 Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE P. D. Kettner (Degree or title)	22b. ADDRESS M.D. Kansas City, Mo	22c. DATE SIGNED 8/3/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE August 5, 1959	23c. NAME OF CEMETERY OR CREMATORY MEMORIAL PARK	23d. LOCATION (City, town, or county) (State) KANSAS CITY KANSAS
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24. FUNERAL DIRECTOR MUEHLEBACH	ADDRESS 6800 TROOST	25. DATE RECD. BY LOCAL REG. 8-3-59	26. REGISTRAR'S SIGNATURE Dora Minchell
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DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

Dr. S. W. Kettner
Prof. Embalming
Rm. 1-2892

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 J. T. Crowell

Licensed Embalmer No. 4904

P. O. Address H. C. M.

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.