

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
 FILED VS AUG 1 0 1959

59-025462

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3631 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) Kansas City | | Length of stay in lb 82 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 St. Mary's Hospital | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 5915 Paseo | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Anna Middle Catherine Last Switzer | | | | 4. DATE OF DEATH Month July Day 26 Year 1959 | | | | | | | | | |
| 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 5-28-1875 | | 9. AGE (last birthday) 84 | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HR | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker | | | | 10b. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (City and state or country) Leavenworth, Kansas | | | 12. CITIZEN OF WHAT COUNTRY USA | | | | |
| 13a. FATHER'S NAME Ferdinand Kleinman | | | | 13b. MOTHER'S MAIDEN NAME Mary M. Huhn | | | | 14. NAME OF HUSBAND OR WIFE Alonza T. Switzer | | | | | |
| 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. none | | 17. INFORMANT Address Ralph A. Switzer, 19 West Concord, K.C.Mo. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subdural haemorrhage | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 10 da | | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Head injury | | | | | | | | | | | | | |
| 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 | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20a. ACCIDENT <input checked="" 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.) Fell going to bathroom - striking head on floor | | | | | | | | | |
| 20c. TIME OF INJURY Hour 2 a.m. - p.m. Month, Day, Year July 17, 1959 | | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Hosp. office | | 20f. CITY, TOWN, OR LOCATION Kans City MO. | | COUNTY Jackson | | STATE MO. | | | |
| 21. I attended the deceased from JAN. 1959 to July 26 '59 and last saw her alive on July 26, '59 Death occurred at 3 P. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | | | | |
| 22a. SIGNATURE (Degree or title) John B. Jester M.D. | | | | | | 22b. ADDRESS 4620 Nichols Pkwy F.C. MO. | | | 22c. DATE SIGNED July 27, '59 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 7-28-59 | | 23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery | | | | 23d. LOCATION (City, town, or county) (State) Kansas City, Missouri | | | | | |
| 24. FUNERAL DIRECTOR Melody-McGilley-Eylar, 20 W. Linwood K.C.Mo. | | | | | 25. DATE RECD. BY LOCAL REG. 7-27-59 | | 26. REGISTRAR'S SIGNATURE Melody-McGilley-Eylar | | | | | | |

BY AFFIDAVIT OF Melody-McGilley-Eylar, M.D. MEDICAL CERTIFICATION B. J. JUSCUC

off. 7. 29. 59.

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STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed Wm. H. Gentry

Licensed Embalmer No. 050

P. O. Address K.C. Mo.

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.