

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-025479

FILED JUL 17 1959

149

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

3249

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Kansas City</b>			Length of stay in lb. <b>3 mo.</b>	c. CITY OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>24th &amp; Tracy - On streets</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>2405 Tracy</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>Neal</b> Last <b>Townes</b>				4. DATE OF DEATH Month <b>June</b> Day <b>29</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Col.</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>12/31/28</b>	9. AGE (last birthday) <b>30</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HR Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Odd Jobs</b>		11. BIRTH-PLACE (City and state or country) <b>Kansas City, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13a. FATHER'S NAME <b>Harry Townes, Sr.</b>			13b. MOTHER'S MAIDEN NAME <b>Juanita</b>		14. NAME OF HUSBAND OR WIFE <b>Deloris Townes</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes 2/13/51 - 2/22/53</b>			16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT Address <b>Deloris Townes - K.C., Mo.</b>		
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) <b>Hemorrhagic Shock</b>							
DUE TO (b) <b>Massive Left Hemothorax</b>							
DUE TO (c) <b>Penetrating Gunshot Wound of Back</b>							
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
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>Gunshot wound</b>					
20c. TIME OF INJURY Hour <b>4:30</b> Month, Day, Year <b>6/30/1959</b> p.m.	20d. INJURY OCCURRED WHILE AT WORK <input checked="" 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.) <b>24th &amp; Tracy</b>		20f. CITY, TOWN, OR LOCATION <b>Kansas City, Jackson, Mo.</b>		COUNTY STATE	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>Deputy coroner</b>				22b. ADDRESS <b>1618 Lydia Rd.</b>		22c. DATE SIGNED <b>6/30/59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>7-6-1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BLUE RIDGE</b>		23d. LOCATION (City, town or county) (State) <b>KANSAS CITY, MO.</b>			
24. FUNERAL DIRECTOR <b>BROWN-HUDSON K.C., Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>7-2-59</b>		26. REGISTRAR'S SIGNATURE <b>Rever Marshall</b>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF TESTIMONY

**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 \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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.