

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-025546

FILED VS AUG 11 1959

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 349 STATE FILE NUMBER

DED

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|--|--|---|--|---|---|--|---|--|--|
| 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 Independence | | Length of stay in lb 6 yrs | | c. CITY OR TOWN Independence | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Rest Haven | | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 1504 W. Truman Road | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) Rachel Victoria McKittrick | | | | 4. DATE OF DEATH Month August Day 5 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 7-8-1870 | | 9. AGE (last birthday) 89 IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home | | | 10b. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (City and state or country) Board Ship Victoria Atlantic Ocean | | 12. CITIZEN OF WHAT COUNTRY USA | | |
| 13a. FATHER'S NAME Agenstein | | | 13b. MOTHER'S MAIDEN NAME Unknown | | | 14. NAME OF HUSBAND OR WIFE William John McKittick | | | |
| 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 Rosie Deards - Omaha Neb. Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute congestive heart failure DUE TO (b) arteriosclerotic + hypertensive cardiovascular disease DUE TO (c) 48 hrs Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Carcinoma of fundus of uterus | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 48 hrs yrs | | |
| 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.) | | | | 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 | |
| 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 2-10-59 to 8-5-59 and last saw her alive on 7-31-59 Death occurred at 1: a. m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | 22a. SIGNATURE (Degree or title) Vance E. Lusk M.D. | | 22b. ADDRESS 10951 W. 11th Rd Independence, Mo | | 22c. DATE SIGNED 8/6/59 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 8-7-59 | | 23c. NAME OF CEMETERY OR CREMATORY Mound Grove | | 23d. LOCATION (City, town, or county) Independence Mo. | | | |
| 24. FUNERAL DIRECTOR Roland R. Speaks | | | | ADDRESS Indep. Mo | | 25. DATE RECD. BY LOCAL REG. 8-7-59 | | 26. REGISTRAR'S SIGNATURE Vance E. Lusk | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 *Roland H. Jensen*
Licensed Embalmer No. 3604

P. O. Address *Indy, Ind.*

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.