

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 1 1959

59-028943

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3958

STATE FILE NUMBER

IDED

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u>		c. CITY OR TOWN <u>KANSAS CITY</u>	
Length of stay in lb <u>LIFE</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>6639 MONTGALL</u>		d. STREET ADDRESS (If outside, give location) <u>6639 MONTGALL</u>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <u>FANNIE EUEL ATKINS</u>			4. DATE OF DEATH Month <u>13</u> Day <u>1959</u> Year		
First Middle Last			Month Day Year		

5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2 10 29</u>	9. AGE (last birthday) <u>92 yrs.</u>	IF UNDER 24 HR Months Days Hours Min.
-------------------------	----------------------------------	---	------------------------------------	--	--

10a. USUAL OCCUPATION (Give kind of work done during preceding working life, even if retired) <u>HOUSEWIFE</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>CLAY COUNTY MO.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
---	-----------------------------------	--	---

13a. FATHER'S NAME <u>FRANCIS MARION EARNES</u>	13b. MOTHER'S MAIDEN NAME <u>HENRIETTA NALL</u>	14. NAME OF HUSBAND OR WIFE <u>JOHN H. ATKINS</u>
--	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT <u>WILLIAM F. ATKINS 6639 MONTGALL</u>	Address
--	--	---	---------

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 <u>minutes</u> <u>years</u>
IMMEDIATE CAUSE (a) <u>Cardiac stand still</u>		
DUE TO (b) <u>Crowned atherosclerosis</u>		
DUE TO (c) <u>Generalized atherosclerosis</u>		
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 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 <u>13</u> 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 <u>LIBERTY MO.</u>	COUNTY	STATE
--	--	--	--------	-------

21. I attended the deceased from June 1955 to 13 Aug 59 and last saw her alive on 13 Aug 59
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Jean B. Willoughby M.D.</u>	(Degree or title)	22b. ADDRESS <u>5905 Mann Kc 13</u>	22c. DATE SIGNED <u>14 Aug 59</u>
--	-------------------	--	--------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>AUG 15, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>FAIRVIEW CEM</u>	23d. LOCATION (City, town, or county) (State) <u>LIBERTY MO.</u>
---	----------------------------------	---	---

24. FUNERAL DIRECTOR <u>D. W. NEWCOMER'S SONS K. CMO.</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>8-15-59</u>	26. REGISTRAR'S SIGNATURE <u>Neva Minshel</u>
--	---------	--	--

DOCUMENT

BY AFFIDAVIT OF JEAN B. WILLOUGHBY MEDICAL CERTIFICATION

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 Albert H. Savage

Licensed Embalmer No. 4812

P. O. Address Kansas City

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.