

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028993

FILED VS SEP 4 1959/49

Registration District No. Primary Registration District No. 1002 Registrar's No. 4058 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Jackson			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Jackson			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 60 Yr.	c. CITY OR TOWN Kansas City		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Westport Nursing H.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 3705 Genesee		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle B. Last BULLOCK			4. DATE OF DEATH Month Aug. Day 20, 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 Dec 25, 1876	9. AGE (last birthday) 82	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Wakefield, Kansas		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME unknown Lawton		13b. MOTHER'S MAIDEN NAME Sarah Kay unknown		14. NAME OF HUSBAND OR WIFE (Dec.) William S. Bullock		
15. WAS DECEASED EVER IN U.S. ARMED SERVICES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 496-07-2393D	17. INFORMANT Everett L. Myers, 7201 Robinson Address CK			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Melanation DUE TO (b) Enter anesthetic Spine DUE TO (c) Serisity Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH	
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 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 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 Aug 2nd - 5th to Aug 24-59 and last saw her/him alive on Aug 18th - 59 . Death occurred at 2:00 p.m. on the date stated above, and to the best of my knowledge from the causes stated.						
22a. SIGNATURE (Degree or title) E.M. Quinn MD			22b. ADDRESS 6030 Troutman P.O. #6		22c. DATE SIGNED 8-21-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Aug. 22, 1959	23c. NAME OF CEMETERY OR CREMATORY Mt. Mariah		23d. LOCATION (City, town, or county) (State) Kansas City, Missouri	
24. FUNERAL DIRECTOR Gates Funeral Home, K.C. Kansas ADDRESS			25. DATE RECD. BY LOCAL REG. 8-21-59	26. REGISTRAR'S SIGNATURE Neva Minshall		

BY AFFIDAVIT OF DOCUMENT 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 Murray Wilson

Licensed Embalmer No. 4989

P. O. Address Parkville,

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.