

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 4 1959 / 49

59-029050

Registration District No. _____ Primary Registration District No. 1002 Registrar's No. 4128 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 1b 52 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) Colonial Nursing Home		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 100 E. 36 th St.

3. NAME OF DECEASED (Type or print) Helena A. Dunham	First Helena	Middle A.	Last Dunham	4. DATE OF DEATH Aug. 24 1959
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5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6-10-1881	9. AGE (last birthday) 78	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse (Retired 6 yrs.)	10b. KIND OF BUSINESS OR INDUSTRY Nursing	11. BIRTHPLACE (City and state or country) Unknown	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Granville A. Dunham	13b. MOTHER'S MAIDEN NAME Elizabeth Sheridan	14. NAME OF HUSBAND OR WIFE None
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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. 197-26-1787-A	17. INFORMANT John H. Hansan	Address 54 E. 53rd Terr. K.C
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid Hemorrhage - 8 hrs		INTERVAL BETWEEN ONSET AND DEATH 8 hrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebral Hemorrhage.		8 hrs.
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) ASHD & Decomposition.		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
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. 6:30	Month, Day, Year July 59
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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 K.C. Mo.	COUNTY Mo.	STATE Mo.
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21. I attended the deceased from **July '59** to **24 Aug 59** and last saw her/him alive on **24 Aug 59**.
a. Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Rufus K. Casebolt MD	(Degree or title)	22b. ADDRESS 4400 Battersville K.C. Mo.	22c. DATE SIGNED 25 Aug 59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 8-26-1959	23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery	23d. LOCATION (City, town, or county) St. Mary's, Kansas
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24. FUNERAL DIRECTOR Melody-McGilley-Eylar	ADDRESS 20 W. Linwood K.C.	25. DATE RECD. BY LOCAL REG. 8-25-59	26. REGISTRAR'S SIGNATURE Neva Marshall
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Missouri

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

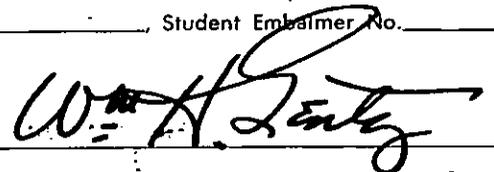
BY AFFIDAVIT OF Rufus K. Casebolt

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. 502

P. O. Address K. C. 4

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.