

**DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-029074**

**FILED VS SEP 1 1959**

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3948 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> COUNTY <b>Jackson</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas</b>		Length of stay in 1b <b>C ity 13 Yrs</b>		c. CITY OR TOWN <b>Kansas City</b>		Inside Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>601 East Armour</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>601 East Armour</b>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Luke</b>			First	Middle	Last	4. DATE OF DEATH Month <b>8</b> Day <b>12</b> Year <b>59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</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>Unk,</b>	9. AGE (last birthday) <b>47</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Apartment</b>		11. BIRTHPLACE (City and state or country) <b>Texas</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>
13a. FATHER'S NAME <b>Unknown</b>			13b. MOTHER'S MAIDEN NAME <b>Unknown</b>			14. NAME OF HUSBAND OR WIFE <b>Willie Fields</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No None</b>			16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Willie Fields 2714 Tracy</b> 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) <b>Stab wound chest</b> DUE TO (b) <b>penetrating heart</b> DUE TO (c) _____ 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 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>Stabbed chest by a</b>					
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year <b>8-12-59</b>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>						
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>His</b>	20f. CITY, TOWN, OR LOCATION COUNTY STATE <b>Kansas City Jackson MO</b>						
21. I attended the deceased from _____, to _____ and last saw him/her alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Hugh A Owens Coroner</b>				22b. ADDRESS <b>1034 Quattro Bldg</b>		22c. DATE SIGNED <b>8-12-59</b>	
23a. BURIAL PREPARATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>8-15-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Blue Ridge Lawn</b>		23d. LOCATION (City, town, or county) (State) <b>Kansas City, Mo.</b>			
24. FUNERAL DIRECTOR <b>Lawrence A. Jones</b>			ADDRESS <b>2304 Vine</b>	25. DATE RECD. BY LOCAL REG. <b>8-14-59</b>	26. REGISTRAR'S SIGNATURE <b>Steve Marshall</b>		

DOCUMENT

MEDICAL CERTIFICATION  
BY AFFIDAVIT OF  
**Hugh A. Owens**

**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 Laurence A. J.  
Licensed Embalmer No. 44

P. O. Address 2304

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