

# DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-029117

FILED VS AUG 21 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. 1002 Registrar's No. 3841 STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Jackson</u> b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u> c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St Luke Hosp</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Jackson</u> c. CITY OR TOWN <u>Kansas City</u> d. STREET ADDRESS (If outside, give location) <u>2001 Indep. Ave</u>	
Length of stay in 1b <u>1 yr.</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	

<b>3. NAME OF DECEASED</b> (Type or print) First <u>Clara</u> Middle <u>Mullinix</u> Last <u>Herrell</u>			<b>4. DATE OF DEATH</b> Month <u>8</u> - Day <u>7</u> - Year <u>59</u>			
<b>5. SEX</b> <u>F</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>7-2-1874</u>	<b>9. AGE</b> (last birthday) <u>85</u>	IF UNDER 1 YEAR Months _____ Days _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Home</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>Lone Star Mo</u>		
<b>12. CITIZEN OF WHAT COUNTRY</b> <u>USA</u>		<b>13a. FATHER'S NAME</b> <u>Benjamin Wiley</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>Elizabeth - ? - Charley Herrell</u>		

<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	<b>16. SOCIAL SECURITY NO.</b> <u>496-03-6472B</u>	<b>17. INFORMANT</b> <u>Ernest Mullinix Greenwood Mo</u> Address _____
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<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1 year</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Thrombosis of femoral vein 1 month</u>	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
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<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)	
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____			
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	
<b>20f. CITY, TOWN, OR LOCATION</b> _____		<b>COUNTY</b> _____ <b>STATE</b> _____	

21. I attended the deceased from June 2, 1959 to Aug. 7, 1959 and last saw her alive on Aug 7 1959  
 Death occurred at Kansas City, MO 8-7-59 11 AM on the date stated above, and to the best of my knowledge, from the causes stated.

<b>22a. SIGNATURE</b> (Degree or title) <u>Clint Miller MD</u>	<b>22b. ADDRESS</b> <u>2001 Independence Ave</u>	<b>22c. DATE SIGNED</b> <u>8-7-59</u>
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<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Funeral</u>	<b>23b. DATE</b> <u>8/9/59</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Pleasant Hill</u>	<b>23d. LOCATION</b> (City, town, or county) (State) <u>Pleasant Hill Mo</u>
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<b>24. FUNERAL DIRECTOR</b> <u>Angels for Funerals Home Lee's Summit</u> ADDRESS _____	<b>25. DATE RECD. BY LOCAL REG.</b> <u>8-8-59</u>	<b>26. REGISTRAR'S SIGNATURE</b> <u>Neva Marshall</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF CLINT L. MILLER

**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 *M. Blangis*

Licensed Embalmer No. 323

P. O. Address Lee's Ave

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.