

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-029137

FILED VS SEP 1 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3961

STATE FILE NUMBER

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| 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) <u>Kansas City</u> | | Length of stay in 1b <u>8 yrs.</u> | c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF HOSPITAL OR INSTITUTION <u>D.O.A. General Hospital</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>536 Gillis</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First <u>ELZA</u> Middle <u>Lloyd</u> Last <u>Inscho</u> | | | 4. DATE OF DEATH Month <u>Aug</u> Day <u>14</u> Year <u>1959</u> | |
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| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input checked="" type="checkbox"/> - Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <u>9/20/1893</u> | 9. AGE (last birthday) <u>65</u> | 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) <u>LABORER</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>GRAIN ELEVATOR</u> | 11. BIRTHPLACE (City and state or country) <u>HAZARD, NEBRASKA, S.F.</u> | 12. CITIZEN OF WHAT COUNTRY |
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| 13a. FATHER'S NAME <u>Edw. Mc Gintey</u> | 13b. MOTHER'S MAIDEN NAME <u>MARY McGinley</u> | 14. NAME OF HUSBAND OR WIFE <u>Dorothy Inscho</u> |
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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) <u>NO</u> | 16. SOCIAL SECURITY NO. <u>500-10-4823</u> | 17. INFORMANT <u>FRANCES HIRTER. 819 COURT ST. St. Joseph, Mo.</u> |
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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) <u>Coronary Occlusion</u> | | INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) | |
| | DUE TO (c) | |

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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) | 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. Month, Day, Year | 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.) | 20f. CITY, TOWN, OR LOCATION | COUNTY | STATE |
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21. I attended the deceased from _____ to _____ and last saw her alive on _____
Death occurred at 8:15 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE (Degree or title) <u>Joseph H. Owens Coroner</u> | 22b. ADDRESS <u>1034 Piedmont Bldg</u> | 22c. DATE SIGNED <u>8-15-59</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (specify) <u>Removal</u> | 23b. DATE <u>8-15-59</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>-</u> | 23d. LOCATION (City, town, or county) (State) <u>St. Joseph, Mo.</u> |
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| 24. FUNERAL DIRECTOR <u>Clark Mortuary, St. Joseph, Mo.</u> | 25. DATE RECD. BY LOCAL REG. <u>8-15-59</u> | 26. REGISTRAR'S SIGNATURE <u>Neva Minshall</u> |
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF HEALTH - 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 _____, Student Embalmer No. _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed John R. Sidmo

Licensed Embalmer No. 453
P. O. Address Kansas

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.