

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

**59-029370**

**FILED VS AUG 21 1959**

149

Registration District No. \_\_\_\_\_ Primary Registration District No. 1002 Registrar's No. 3887 STATE FILE NUMBER

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) OR TOWN <u>Kansas City</u>		Length of stay in 1b <u>App. 58 yrs.</u>		c. CITY OR TOWN <u>Kansas City</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>General Hospital</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>1100 E. 9th</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Agnes</u> Middle <u>May</u> Last <u>Wells</u>				4. DATE OF DEATH Month <u>8</u> Day <u>8</u> Year <u>59</u>									
5. SEX <u>Female</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 type="checkbox"/>		8. DATE OF BIRTH <u>10-29-1900</u>		9. AGE (last birthday) <u>58</u>		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) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Spring Hill, Kans.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S.</u>					
13a. FATHER'S NAME <u>Everett J. Mathews</u>				13b. MOTHER'S MAIDEN NAME <u>Minnie Johnston</u>				14. NAME OF HUSBAND OR WIFE <u>J. C. Wells</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>557-38-6643</u>		17. INFORMANT Address <u>Mr. J. C. Wells 1100 E. 9th.</u>							
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>uremia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>pyelonephritis</u> DUE TO (c) _____										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) <u>paraplegia</u>										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 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 _____ a.m. _____ p.m.		Month, Day, Year											
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 <u>7-16-59</u> to <u>8-8-59</u> and last saw <sup>her</sup> <del>him</del> <u>live</u> on <u>8-8-59</u> Death occurred at <u>2:00 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <u>Abram Gelperin</u>						22b. ADDRESS <u>2400 Cherry</u>				22c. DATE SIGNED <u>8/10/59</u> (State)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>AUG-11-1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Elmwood</u>		23d. LOCATION (City, town, or county) <u>Kansas City, Mo.</u>							
24. FUNERAL DIRECTOR ADDRESS <u>C. H. Blackman &amp; Son K. C. Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>8-10-59</u>		26. REGISTRAR'S SIGNATURE <u>Neva Minshall</u>							

DOCUMENT

BY AFFIDAVIT OF Abram Gelperin 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 Bert B. Bess

Licensed Embalmer No. 468

P. O. Address H. C.,

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.