

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-029394

STATE FILE NUMBER

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4123

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) OR TOWN Kansas City		Length of stay in 1b 15 Months	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) HOSPITAL OR INSTITUTION Research Hosp.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 511 West 11th. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) IRENE W. WOODS			4. DATE OF DEATH Month Aug Day 21 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Aug 2, 1876	9. AGE (last birthday) 83	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) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Springhill, Kansas		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Robert Wilson		13b. MOTHER'S MAIDEN NAME (unknown) Hensey		14. NAME OF HUSBAND OR WIFE Webster F. Woods		
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. 514 09 6691		17. INFORMANT Estella W. Sanderson, 511 W. 11th St., R.C., Missouri		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH 1 hr ?
IMMEDIATE CAUSE (a) Acute myocardial infarction		
Conditions, if any, which gave rise to above cause (a), above the underlying cause last.	DUE TO (b) Severe anemia, secondary to metastatic	
DUE TO (c) carcinoma, primary undetermined		
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 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.)
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____	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 8-19-59 to 8-21-59 and last saw her him alive on 8-21-59
Death occurred at 7:50 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Wilson H. Miller, M.D.</i> (Degree or title)	22b. ADDRESS <i>4620 Ind. Ave. Kansas City, Mo.</i>	22c. DATE SIGNED <i>8-24-59</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8-24-59	23c. NAME OF CEMETERY OR CREMATORY Forest Hill
23d. LOCATION (City, town, or county) Kansas City, Mo		(State)

24. FUNERAL DIRECTOR Stine & McClure, Kansas City, Mo. Undertaking Company	25. DATE RECD. BY LOCAL REG. 8-24-59	26. REGISTRAR'S SIGNATURE <i>Neva Marshall</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF
Wilson H. 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 William M. [Signature]

Licensed Embalmer No. 464

P. O. Address Kansas City

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.