

# DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

## 59-029466

FILED VS AUG 17 1959 *50*

Registration District No. \_\_\_\_\_ Primary Registration District No. *5572* Registrar's No. *181*

STATE FILE NUMBER

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <b>Jackson</b>	b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Prairie Twp.</b>	a. STATE <i>Mo</i>	b. COUNTY <i>Jackson</i>
Length of stay in 1b <i>22 yrs</i>		c. CITY OR TOWN <i>Kansas City</i>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Jackson County Hosp.</b>		d. STREET ADDRESS <i>2935 Troost</i>	(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

<b>3. NAME OF DECEASED</b> (Type or print)			<b>4. DATE OF DEATH</b>				
First <i>James</i>	Middle -----	Last <i>MANNING</i>	Month <i>Aug.</i>	Day <i>11,</i>	Year <i>1959</i>		
<b>5. SEX</b> <i>m</i>	<b>6. COLOR OR RACE</b> <i>W</i>	<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> <i>8/24/1885</i>	<b>9. AGE (last birthday)</b> <i>73</i>	<b>IF UNDER 1 YEAR</b>	<b>IF UNDER 24 HR</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Unknown</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Unknown</i>		11. BIRTHPLACE (City and state or country) <i>Unknown</i>		12. CITIZEN OF WHAT COUNTRY <i>Unknown</i>	

<b>13a. FATHER'S NAME</b> <i>Unknown</i>		<b>13b. MOTHER'S MAIDEN NAME</b> <i>Unknown</i>		<b>14. NAME OF HUSBAND OR WIFE</b> <i>Unknown</i>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <i>Unknown</i>			<b>16. SOCIAL SECURITY NO.</b> <i>Unknown</i>		<b>17. INFORMANT</b> <i>Indep. Mo. Jackson County Hospital Records.</i>

<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY:		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
IMMEDIATE CAUSE (a) <i>Arteriosclerotic heart disease</i>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>Generalized arteriosclerosis</i>		
	DUE TO (c)		
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

<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" 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"/> <b>NOT WHILE AT WORK</b> <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 <i>Jan 15-57</i> to <i>Aug 11-59</i> and last saw <sup>her</sup> him alive on <i>Aug 11-1959</i> Death occurred at <i>8:30 p.m.</i> on the date stated above, and to the best of my knowledge, from the causes stated.				

<b>22a. SIGNATURE</b> <i>Philip Laper M.D.</i> (Degree or title)		<b>22b. ADDRESS</b> <i>Lee's Summit Mo</i>		<b>22c. DATE SIGNED</b> <i>8/11/59</i> (State)
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<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <i>Anatomical</i>	<b>23b. DATE</b> <i>Aug. 12, 1959</i>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <i>Univ. Of Kansas City</i>	<b>23d. LOCATION</b> (City, town, or county) (State) <i>Kansas City, Mo.</i>
<b>24. FUNERAL DIRECTOR</b> <i>Langsford Funeral Home</i> <i>Lee's Summit, Missouri</i>		<b>25. DATE RECD. BY LOCAL REG.</b> <i>Aug 12-1959</i>	<b>26. REGISTRAR'S SIGNATURE</b> <i>N. B. Langsford</i>

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 N. B. Langford

Licensed Embalmer No. 147

P. O. Address Des Moines

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.