

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. SEP 25 1959

149

Registration District No.          Primary Registration District No. 1302 Registrar's No.         

4483

59-032226

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>Mo.</u> b. COUNTY <u>Clay</u>												
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Length of stay in 1b <u>4 yrs</u>		c. CITY OR TOWN <u>KC 16 Mo.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>										
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Beacon Hill Rest Home</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>2 East 43rd Ave.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>Elsie</u> Middle <u>A</u> Last <u>BLACKMAN</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>15</u> Year <u>1959</u>												
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>12-11-71</u>	9. AGE (last birthday) <u>87</u>	IF UNDER 1 YEAR Months <u>        </u> Days <u>        </u> Hours <u>        </u> Min. <u>        </u>	IF UNDER 24 HR Hours <u>        </u> Min. <u>        </u>									
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>Van Wert Ohio</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>									
13a. FATHER'S NAME <u>William Tindall</u>			13b. MOTHER'S MAIDEN NAME <u>Amy Chilcote</u>			14. NAME OF HUSBAND OR WIFE <u>L. S. Blackman</u>										
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>no</u>		17. INFORMANT <u>Mrs Elsie Tyson of the Home</u>			Address								
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									
IMMEDIATE CAUSE (a) <u>Chronic recurrent anemia + malnutrition</u>							<u>6 months</u>									
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Blood con</u>							<u>4-5 years</u>									
DUE TO (c) <u>Benign prostatic cell carcinoma bladder</u>							<u>4-5 years</u>									
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 <u>        </u> Month, Day, Year <u>        </u> a.m. <u>        </u> p.m. <u>        </u>		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>October, 1957</u> to <u>Sept 15, 1959</u> and last saw her alive on <u>Sept 9, 1959</u> Death occurred at <u>4:40 AM</u> m on the date stated above, and to the best of my knowledge, from the causes stated.																
22a. SIGNATURE (Degree or title) <u>S. Conner Bates M.D.</u>						22b. ADDRESS <u>2730 South Mall Antioch Center, Kansas City 19, Mo</u>				22c. DATE SIGNED <u>9/15/59</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE <u>9-15-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>			23d. LOCATION (City, town, or county) <u>Van Wert Ohio</u>			(State)							
24. FUNERAL DIRECTOR <u>R.W. Newcomer's Sons</u>				ADDRESS <u>76 K.P. Mo</u>		25. DATE RECD. BY LOCAL REG. <u>9-15-59</u>		26. REGISTRAR'S SIGNATURE <u>Neva Marshall</u>								

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Gomer Bates

**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 Stewart H. Hill

Licensed Embalmer No. 4586

P. O. Address K.C. 18, Mo.

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.