

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-032378

FILED VS OCT 7 1959

149 Primary; Registration District No. 1002 Registrar's No. 4611 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Jackson b. CITY (If outside corporate limits, give TOWNSHIP, only) OR TOWN Kansas City Length of stay in: 42 years		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) 3927 Charlotte Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION 3927 Charlotte Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 3927 Charlotte Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last Florence Harvey			4. DATE OF DEATH Month Day Year September 21 1959		
5. SEX Female	6. COLOR OR RACE Caucasian	7. Married <input checked="" type="checkbox"/> Never Married: <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Nov 27 1891	9. AGE (last birthday) 67 years	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (City and state or country) Otego, Kansas	
13a. FATHER'S NAME Benjamin Shively		13b. MOTHER'S MAIDEN NAME Catherine Ratz		14. NAME OF HUSBAND OR WIFE Shelby E. Harvey	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/>	16. SOCIAL SECURITY NO. None	17. INFORMANT Address Shelby E. Harvey 3927 Charlotte, K.C., Mo
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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) Bronchogenic Carcinoma Lung	INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Arteriosclerotic Heart Disease	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 SUICIDE HOMICIDE <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) None.
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year none		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 _____

21. I attended the deceased from April 1946 to Sept 21, 59 and last saw her alive on Sept 11, 59
 Death occurred at 4:00 pm on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Degree or title <i>Don J. Boney MD</i>	22b. ADDRESS 217 Rega Two Bay MO	22c. DATE SIGNED 9/22/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Sept 23, 1959	23c. NAME OF CEMETERY OR CREMATORY Mount Moriah Cemetery	23d. LOCATION (City, town, or county) (State) Kansas City, Missouri
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24. FUNERAL DIRECTOR ADDRESS Muhlebach 6800 Troost	25. DATE RECD. BY LOCAL REG. 9-22-59 26. REGISTRAR'S SIGNATURE <i>Neva Marshall</i>
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DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

Mr. [unclear]
[unclear]

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 *R. E. Widale*

Licensed Embalmer No. *4997*

P. O. Address *K. C. 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.