

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-032420

FILED VS. OCT 7 1959 149

Registration District No. 1002 Registrar's No. 4542

STATE FILE NUMBER

IDED

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Kansas City</b>			Length of stay in 1b <b>19 Yrs.</b>		c. CITY OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF HOSPITAL OR INSTITUTION <b>Trinity Lutheran Hosp.</b>				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>5909 Olive St.</b>	
3. NAME OF DECEASED (Type or print) <b>Nellie</b>		First		Middle <b>(None)</b>		Last <b>Jones</b>	
4. DATE OF DEATH <b>Sept. 17, 1959</b>		Month		Day		Year	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>2/18/1881</b>	
9. AGE (last birthday) <b>78</b>		IF UNDER 1 YEAR Months		IF UNDER 24 HR. Days		Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Rising City, Neb.</b>	
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>				13a. FATHER'S NAME <b>George Ingalls</b>		13b. MOTHER'S MAIDEN NAME <b>Lena Dorn</b>	
14. NAME OF HUSBAND OR WIFE <b>Wilford Jones</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Kansas City Missouri</b> <b>Miss Ethel Jones 5909 Olive Street</b>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Congestive Heart Failure</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Chronic Bronchial Asthma</b> DUE TO (c) <b>Allergy (Respiratory)</b> 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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>			
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 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 <b>9/14/1959</b> to <b>9/17/59</b> and last saw her <sup>her</sup> alive on <b>9/17/59</b> Death occurred at <b>4:48</b> <sup>p.m.</sup> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Mary C. Cortner, M.D.</b>				22b. ADDRESS <b>4526 Pacer</b>		22c. DATE SIGNED <b>9/18/59</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>9/21/1959</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rising Sun Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Rising City Nebraska</b>	
24. FUNERAL DIRECTOR <b>D.W. Newcomers Sons Kansas City, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>9-18-59</b>		26. REGISTRAR'S SIGNATURE <b>Thora Minshall</b>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Mary C. Cortner

**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 Norman W. Holson

Licensed Embalmer No. 4889

P. O. Address D. C. 2710

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.