

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-032465

FILED VS SEP 25 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4464 STATE FILE NUMBER

1. PLACE OF DEATH				2. USUAL RESIDENCE (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>Kansas City</b>		a. STATE <b>Missouri</b>		b. COUNTY <b>Jackson</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>3117 E. 19th St. Ter.</b>		Length of stay in lb <b>16 yrs.</b>		c. CITY OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. STREET ADDRESS <b>3117 E. 19th St. Ter.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>3117 E. 19th St. Ter.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First <b>Charles</b>		Middle <b>J.</b>		Last <b>McKenzie</b>		Month Day Year <b>Sept. 12, 1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>1/31/1895</b>	9. AGE (last birthday) <b>64</b>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>City Natl. Bank</b>		11. BIRTHPLACE (City and state or country) <b>Kansas City, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13a. FATHER'S NAME <b>Charles McKenzie</b>			13b. MOTHER'S MAIDEN NAME <b>Kathleen Deegan</b>		14. NAME OF HUSBAND OR WIFE <b>Grace A. McKenzie</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>yes World War # 1</b>		16. SOCIAL SECURITY NO. <b>566-16-6859</b>		17. INFORMANT Address <b>Grace A. McKenzie 3117 E. 19th. Ter.</b>			
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) <b>Coronary Occlusion</b>							
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)				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, 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 _____ to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Hugh H. Owens Coroner</b>				22b. ADDRESS <b>1034 Rialto Bldg</b>		22c. DATE SIGNED <b>9-12-59</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>Sept. 15, 1959</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. St. Marys Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Kansas City, Missouri</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Earp &amp; Sons 4707 Truman Rd. K. C. Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>9-14-59</b>		26. REGISTRAR'S SIGNATURE <b>Walter Marshall</b>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Hugh H. Owens

**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 H. Eary

Licensed Embalmer No. 4728

P. O. Address H. C. 7

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.