

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-032513

EILED VS SEP 25 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4364 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>Missouri</u> b. COUNTY <u>JACKSON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u>		Length of stay in lb <u>4 yrs</u>	c. CITY OR TOWN <u>KANSAS CITY</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>D.O.A. GEN. HOSPT</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1214 MONTGOM</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>HOMER</u> Middle <u>D. HESTER</u> Last <u>PACE</u>			4. DATE OF DEATH Month <u>9</u> Day <u>5</u> Year <u>1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COL.</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12-31-1929</u>	9. AGE (last birthday) <u>29</u>	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) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>LANDSCAPE</u>		11. BIRTHPLACE (City and state or country) <u>WARREN, ARK.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>HOMER PACE</u>		13b. MOTHER'S MAIDEN NAME <u>CARRIE TIDWELL</u>		14. NAME OF HUSBAND OR WIFE <u>DAISY PACE</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>unk.</u>	17. INFORMANT Address <u>DAISY PACE K.C., MO.</u>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Internal Thoracic Hemorrhage.</u>		INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) _____		
DUE TO (c) <u>Penetrating Gunshot Wound of Rt. Heart.</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 checked="" 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>8:50</u> p.m. Month, Day, Year <u>Sept. 5, 1959</u>	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.) <u>13th & Woodland</u>		20f. CITY, TOWN, OR LOCATION <u>Kansas City, Jackson, Mo.</u>	COUNTY STATE
21. I attended the deceased from _____, to _____ and last saw him/her alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE (In case of this) <u>Deputy coroner</u>		22b. ADDRESS <u>1618 Lydia Ave</u>		22c. DATE SIGNED <u>9/2/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9-12-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Blue Ridge Lawn</u>	23d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Manlove & Williams 1729 Lydia</u>		25. DATE RECD. BY LOCAL REG. <u>K.C., Mo 9-8-59</u>	26. REGISTRAR'S SIGNATURE <u>new Minshall</u>	

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF M. T. Williams

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.