

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-032910

FILED VS. SEP 29 1959 74

Registration District No. _____ Primary Registration District No. 3035 Registrar's No. 71

STATE FILE NUMBER

DOCUMENT K.C. Bd. of Elect. Comm.-Record

1. PLACE OF DEATH a. COUNTY <u>Hayfette</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lexington Mo.</u>		Length of stay in 1b <u>5 Mos.</u>	c. CITY OR TOWN <u>Kansas City</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>314 S. 10th</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>2327 Montgall</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Ethel</u> Middle <u>Dorriey</u> Last <u>Dewey</u>			4. DATE OF DEATH Month <u>August</u> Day <u>25</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 21, 1899</u>	9. AGE (last birthday) <u>59</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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 <u>own home</u>		11. BIRTHPLACE (City and state or country) <u>Wichita, Kans.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>Marion Pollard</u>		13b. MOTHER'S MAIDEN NAME <u>SARA WATSON</u>		14. NAME OF HUSBAND OR WIFE <u>Thomas Dewey</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>None</u>	17. INFORMANT <u>Cozette Hayter</u> Address <u>8220 W. Wood</u>
---	--	--	---

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>Cerebral hemorrhage</u>		<u>3 wks</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Hypertension and Arterial</u>	
	DUE TO (c) <u>Sclerosis</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 _____ 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 August 18, 1959 - 8-25-59 and last saw her/him alive on 8-18-59
Death occurred at about 4:30 PM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Ben H. Brasher MD</u>		22b. ADDRESS <u>Lexington, Mo</u>		22c. DATE SIGNED <u>8/27/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8-29-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Woodland</u>	23d. LOCATION (City, town, or county) (State) <u>Independence, Mo</u>	

24. FUNERAL DIRECTOR <u>Watkins Bros. 18th Benton</u>		25. DATE REG. BY LOCAL REG. <u>9-14-59</u>	26. REGISTRAR'S SIGNATURE <u>Maureen E. Gattis</u>
--	--	---	---

BY AFFIDAVIT OF INFORMANT

MEDICAL CERTIFICATION

5961 68 433

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 Bruce R. Walker

Licensed Embalmer No. 4800

P. O. Address 1844 Bent

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.