

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-034928

FILED VS OCT 13 1959 381

STATE FILE NUMBER

Registration District No. 381 Primary Registration District No. 4515 Registrar's No. 98

ENDED

1. PLACE OF DEATH a. COUNTY <u>SUTTON</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>SUTTON</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>MILAN</u>		Length of stay in 1b		c. CITY OR TOWN <u>MILAN</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>SUTTON CO MEM'L HOSP</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>SARAH</u> Middle <u>OSA</u> Last <u>KENLEY</u>				4. DATE OF DEATH Month <u>OCT</u> Day <u>3</u> Year <u>59</u>					
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>8-16-1924</u>	9. AGE (last birthday) <u>64</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE KEEPER</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>HOTEL MAID</u>		11. BIRTHPLACE (City and state or country) <u>POITOCK MO</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>GEORGE WASHINGTON WHITE</u>			13b. MOTHER'S MAIDEN NAME <u>ESTHER ANN ROOPE</u>			14. NAME OF HUSBAND OR WIFE <u>WALTER KENLEY</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>493-18-4950</u>		17. INFORMANT <u>MOSENE WHITE</u>			Address <u>MILAN 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>Carcinoma of right breast</u>							INTERVAL BETWEEN ONSET AND DEATH <u>18 mo.</u>		
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 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 <u>April 1, 1958</u> to <u>Oct 3, 1959</u> and last saw her <u>alive</u> on <u>Oct. 3, 1959</u> Death occurred at <u>11:40 P</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>V.L. Robinson, D.O.</u> (Degree or title)				22b. ADDRESS <u>Milam, Mo.</u>		22c. DATE SIGNED <u>10-4-59</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>OCT 6 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CHARWOOD</u>		23d. LOCATION (City, town, or county) <u>MILAM</u>		(State) <u>MO</u>			
24. FUNERAL DIRECTOR <u>Biggs Funeral Home</u>		ADDRESS <u>Milam</u>		25. DATE RECD. BY LOCAL REG. <u>10-6-1959</u>		26. REGISTRAR'S SIGNATURE <u>Mrs M.W. Beckett</u>			

DOCUMENT

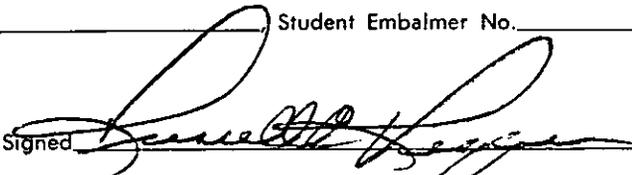
MEDICAL CERTIFICATION

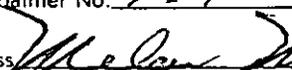
BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me
or by _____ Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed  _____
Licensed Embalmer No. 3792

P. O. Address  _____

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.