

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-036221

FILED VS. OCT 23 1959

149

Primary Registration District No. 1002

Registrar's No.

4929

STATE FILE NUMBER

RECEIVED

1. PLACE OF DEATH a. COUNTY Jackson			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Jackson		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 9 Yrs.	c. CITY OR TOWN Kansas City		Inside Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4011 East 26th			Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4011 East 26th	

3. NAME OF DECEASED (Type or print) First Dorsey Middle Holly Last Holly			4. DATE OF DEATH Month 10 Day 8 Year 59		
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5. SEX Male	6. COLOR OR RACE Negro	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Unknown	9. AGE (last birthday) 35	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY Automobile	11. BIRTHPLACE (City and state or country) Hugo, Oklahoma	12. CITIZEN OF WHAT COUNTRY U. S. A.
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13a. FATHER'S NAME Sylvester Holly	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Lexine Holly
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 462-30-8068	17. INFORMANT Lexine Holly Address 4011 East 26
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Dilatation of Right Heart		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Chronic Cardiac Hypertrophy	
	DUE TO (c) Chronic Bilateral Adhesive Pleuritis	
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.)
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20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> 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
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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 Deputy Coroner	22b. ADDRESS 1618 Lydia Ave.	22c. DATE SIGNED 10/9/59
23a. BURIAL, CREMATION, or other disposal (Specify) Burial	23b. DATE Oct. 20, 59	23c. NAME OF CEMETERY OR CREMATORY Blue Ridge Lawn
23d. LOCATION (City, town, or county) Kansas City, Mo.		

24. FUNERAL DIRECTOR Lawrence A. Jones ADDRESS 2304 Vine St.	25. DATE RECD. BY LOCAL REG. 10-13-59	26. REGISTRAR'S SIGNATURE Neva Minchall
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

L. M. Hillman

0300 7 2 1104

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8000-00-1000

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 Leanne A. Jones

Licensed Embalmer No. 447

P. O. Address 230 4th
NC 27111

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.