

**JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-036231**

STATE FILE NUMBER

FILED VS NOV 2 1959 149

Primary Registration District No. 1002 Registrar's No. 4957

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in 1b <b>20 yrs</b>	c. CITY OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>General Hospital</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>2723 Wabash</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Willa</b> Middle <b>Avela</b> Last <b>Hutton</b>			4. DATE OF DEATH Month <b>10</b> Day <b>14</b> Year <b>59</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>Negro</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>2 16 1909</b>	9. AGE (last birthday) <b>50</b> IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>silk finisher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S Air Force</b>		11. BIRTHPLACE (City and state or country) <b>Van Buren Ark.</b>	12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13a. FATHER'S NAME <b>George Fuller</b>		13b. MOTHER'S MAIDEN NAME <b>Millie Nash</b>		14. NAME OF HUSBAND OR WIFE <b>none</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>432-05-8898</b>	17. INFORMANT Address <b>Millie Trice 2723 Wabash Ave.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration pneumonia</b>					INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Sub- arachnoid hemorrhage</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 <b>10-12-59</b> to <b>10-14-59</b> and last saw her alive on <b>10-14-59</b>		Death occurred at <b>11:15</b> P.M. on the date stated above, and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE (Degree or title) <b>Abraham Gelpert M.D.</b>			22b. ADDRESS <b>2400 Cherry, Kansas City, Mo</b>		22c. DATE SIGNED <b>10-15-59</b>	
23a. BURIAL, CREMATION REMOVAL (Specify) <b>remove</b>	23b. DATE <b>10 17 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Smith Cem</b>	23d. LOCATION (City, town, or county) (State) <b>Ft. Smith Ark.</b>			
24. FUNERAL DIRECTOR ADDRESS <b>Adkins Funeral Home 2000 E 12st K.C. Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>10-15-59</b>	26. REGISTRAR'S SIGNATURE <b>Gene Marshall</b>			

DOCUMENT

BY AFFIDAVIT OF Abraham Gelpert M.D. MEDICAL CERTIFICATION

**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 *Edward P. Keyser*

Licensed Embalmer No. 4437

P. O. Address Kenna

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.