

FEDERAL BUREAU OF INVESTIGATION - DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS OCT 23 1959

59-036255

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4824

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 1b <u>40 yr.</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>327 A. Baseo</u>			Include Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>327 A. Baseo</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Elsie</u> Middle <u>Mae</u> Last <u>Land</u>				4. DATE OF DEATH Month <u>10</u> Day <u>4</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>1/1/1894</u>	9. AGE (last birthday) <u>65</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>Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nursing</u>		11. BIRTHPLACE (City and state or country) <u>Ray County, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Issac Land</u>			13b. MOTHER'S M maiden NAME <u>Martha Wade</u>		14. NAME OF HUSBAND OR WIFE <u>—</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>unknown</u>		17. INFORMANT Address <u>Miss Grace Land Polo, 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>Coronary Occlusion</u>						INTERVAL BETWEEN ONSET AND DEATH <u>45 days.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						DUE TO (b) <u>Hypertension C.V.R. disease</u> <u>10 yrs.</u>	
						DUE TO (c) <u>with Decomensation</u> <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Lt. Neplustomy 1941</u>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 <u>—</u> a.m. <u>—</u> p.m. <u>—</u> Month, Day, Year <u>—</u>							
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>245</u> <u>8-10-53</u> to <u>10-4-59</u> and last saw her alive on <u>10-3-59</u> Death occurred at <u>P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Frank Leitz M</u>				22b. ADDRESS <u>1530 Prof Bldg. Town Ctr. Mo</u>		22c. DATE SIGNED <u>10-5-59</u>	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>10-7-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Garden Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Excelsior Springs, Mo.</u>		
24. FUNERAL DIRECTOR <u>C. H. Blackman & Son Inc. H. R. Mo.</u>			ADDRESS <u>10-6-59</u>		25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE <u>vera Marshall</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Frank Leitz

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 _____

W.C. Quinn

Licensed Embalmer No. 4879

P. O. Address K.C., Mo.

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.