

PURI DIVISION - OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-036352

FILED VS. OCT 23 1959 / 49

Registration District No. _____ Primary Registration District No. 1002 Registrar's No. 4905

STATE FILE NUMBER

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		c. CITY OR TOWN KANSAS CITY	
Length of stay in lb 9 yrs.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION RESEARCH HOSP.		d. STREET ADDRESS (If outside, give location) 4717 1/2 TROOST	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First JOHN Middle F. Last QUINN			4. DATE OF DEATH Month OCT Day 10 Year 1959		
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5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH MAY 10, 1902	9. AGE (last birthday) 57 yrs.	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) MEXICO	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME JOHN J. QUINN	13b. MOTHER'S MAIDEN NAME MAYME T. GREEN Breen	14. NAME OF HUSBAND OR WIFE ELLEN D. QUINN
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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. 512-14-4623	17. INFORMANT Kansas City Missouri Mrs. Ellen D. Quinn 4717 1/2 Troost Avenue
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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) Peritonitis, generalized		INTERVAL BETWEEN ONSET AND DEATH 2 days	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Perforated gastric ulcer		2 days
	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
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19. WAS AUTOPSY PERFORMED? YES <input checked="" 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 _____ 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
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21. I attended the deceased from **9 Oct 1959** to **10 Oct 1959** and last saw him alive on **9 Oct. 1959**
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22. SIGNATURE (Degree or title) Warrent Wilhelm, M.D.	22b. ADDRESS Prof. Bldg. - Kansas City 6, Mo	22c. DATE SIGNED 11 Oct 1959
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23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE OCT 12, 1959	23c. NAME OF CEMETERY OR CREMATORY MEMORIAL PARK CEM	23d. LOCATION (City, town, or county) KANSAS CITY, MO.
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24. FUNERAL DIRECTOR ADDRESS D. W. NEWCOMER'S SONS K. C. MO.	25. DATE RECD. BY LOCAL REG. 10-12-59	26. REGISTRAR'S SIGNATURE Neva Minshall
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Warrent F. Wilhelm

Dr. Warr. - Fossil

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 *Chester K Brown*

Licensed Embalmer No. *4931*

P. O. Address *K P W*

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.