

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-036484

FILED VS NOV 2 1959

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5031

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>60 Years</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>Lindeman Nursing Home</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>226 West 53rd Street</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>FLORIBEL</b>				First Middle Last <b>WHITEHEAD</b>		4. DATE OF DEATH Month Day Year <b>Oct. 15, 1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 8, 1885</b>	9. AGE (last birthday) <b>73</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - -</b>		11. BIRTHPLACE (City and state or country) <b>Sedalia, Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>S. Needles</b>			13b. MOTHER'S MAIDEN NAME <b>Elma Bray</b>			14. NAME OF HUSBAND OR WIFE <b>Joseph W. Whitehead</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>None</b>		17. INFORMANT Address <b>Joseph W. Whitehead, 226 W. 53rd, K.C., Mo.</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>Globuloma multiforme of the frontal lobe</b>						INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs +</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>frontal lobe</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) <b>Arteriosclerosis generalized</b>						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 Month, Day, Year a.m. p.m.							
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>August 10, 59</b> to <b>October 15, 59</b> and last saw her alive on <b>October 15, 59</b> . Death occurred at <b>4 p.m. at City, Mo.</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Annice V. Armes M.D.</b>				22b. ADDRESS <b>4635 Wyanadale K. City Mo.</b>		22c. DATE SIGNED <b>10-16-59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Oct. 19, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mount Washington Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Kansas City, Missouri</b>		
24. FUNERAL DIRECTOR ADDRESS <b>FREEMAN MORTUARY, Kansas City, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>10-19-59</b>		26. REGISTRAR'S SIGNATURE <b>Neva Minshall</b>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF ANNICE V. ARMES

**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 Clayton Barnes

Licensed Embalmer No. 4793

P. O. Address K. E. Moore

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.