

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-036533

FILED VS NOV 4 1959 146

3026

481

STATE FILE NUMBER

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

ENDED

1. PLACE OF DEATH a. COUNTY JACKSON				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY JACKSON			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN INDEPENDENCE		Length of stay in lb 10 days		c. CITY OR TOWN KANSAS CITY MO		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) 1525 STEELING HOSPITAL OR INSTITUTION O'ROAKE NURSING				d. STREET ADDRESS (If outside, give location) 6102 N. Michigan		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First THERSEA Middle LYNN Last Thompson				4. DATE OF DEATH Month 10 Day 29 Year 1959			
5. SEX F.	6. COLOR OR RACE W.	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH SEPT 24 1936	9. AGE (last birthday) 3	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) KANSAS CITY MO.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME EUGENE Thompson			13b. MOTHER'S MAIDEN NAME PATRICIA Turley		14. NAME OF HUSBAND OR WIFE		
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. none		17. INFORMANT EUGENE Thompson		Address K.C. MO. 6102 N. Michigan	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Unknown (Aspiration of Vomitus?)							
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							
DUE TO (b) Cerebral Palsy							
DUE TO (c) Congenital							
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 checked="" 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 10-29-59 , to 10-29-59 and last saw her alive on 10-29-59 Death occurred at 9:30 am on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Stanford F. Cockerell M.D.				22b. ADDRESS 11037 Wiggins Rd.		22c. DATE SIGNED 10-29-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10-31-1959	23c. NAME OF CEMETERY OR CREMATORY FLORAL HILLS		23d. LOCATION (City, town, or county) (State) KANSAS CITY MO.		
24. FUNERAL DIRECTOR Floral Hills Memorial Chapels			ADDRESS K.C. MO	25. DATE RECD. BY LOCAL REG. 10-30-59	26. REGISTRAR'S SIGNATURE James Harris		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Forest D. Goldsnow

Licensed Embalmer No. 4714

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.