URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS NOV 2 1959

59–036587
STATE FILE NUMBER

ENDED

Registration District No. 150 Primary Registration District No. 5572 Registrar's No. 238

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

1. PLACE OF DEATH
a. COUNTY: Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Rural Prairie — Length of stay in 1b: 50 yrs.
c. FULL NAME OF HOSPITAL OR INSTITUTION: Jackson Co. Hosp — Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo. b. COUNTY: Jackson
c. CITY OR TOWN: Greenwood, Mo — Inside Limits: Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location): Town — Reside on Farm: Yes ☐ No ☑

3. NAME OF DECEASED (Type or print): First: Alice Middle: E. Last: Willsey
4. DATE OF DEATH: Month: 10 Day: 21 Year: 1959
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 6/5/78
9. AGE (last birthday): 81 — 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): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (City and state or country): Jackson Co. Mo.
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: John Burns Drenning
13b. MOTHER'S MAIDEN NAME: Loucetta C. Frost
14. NAME OF HUSBAND OR WIFE: Charles Willsey Dec.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service): ------
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs. Carl Weberg, Address: Salena, Kansas

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Heart disease
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Generalized arteriosclerosis
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:
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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 November 1958, to Oct. 21, 1959 and last saw him/her alive on Oct 21, 1959
Death occurred at 2:15 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Philip Fagan (Degree or title): M. D.
22b. ADDRESS: Lees Summit, Mo
22c. DATE SIGNED: 10/31/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Oct. 22, 1959
23c. NAME OF CEMETERY OR CREMATORY: Greenwood Cemetery
23d. LOCATION (City, town, or county) (State): Greenwood, Mo.

24. FUNERAL DIRECTOR: Langsford Funeral Home, ADDRESS: Lee's Summit
25. DATE RECD. BY LOCAL REG.: 10-22-1959
26. REGISTRAR'S SIGNATURE: M. B. Langsford

(Licensed Embalmer's Statement on Reverse Side)

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_____ Signed N. B. Langford

Signature of Student Embalmer

Licensed Embalmer No. 4962

P. O. Address Lees Summit

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp 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.