URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS NOV 25 1959

59-039375
STATE FILE NUMBER

AMENDED

Registration District No. 73 Primary Registration District No. 5291 Registrar's No. 126

1. PLACE OF DEATH
a. COUNTY: Clay
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Liberty
Length of stay in 1b: 6 Mo.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: I.O.O.F. Hospital
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo. b. COUNTY: Clay
c. CITY OR TOWN: Kansas City No.
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 616 East 43 Terr No.
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Harriett Middle: May Last: Baldwin

4. DATE OF DEATH: Month: Nov. Day: 7 Year: 59

5. SEX: Female

6. COLOR OR RACE: White

7. Married ☒ **Never Married** ☐ **Widowed** ☐ **Divorced** ☐

8. DATE OF BIRTH: 10/16/1885

9. AGE (last birthday): 74

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:

11. BIRTHPLACE (City and state or country): Joplin Mo.

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Jim McCaslin

13b. MOTHER'S MAIDEN NAME: Jennie Unknown

14. NAME OF HUSBAND OR WIFE: Carlton Baldwin

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: Carlton Baldwin Address: Of The Home

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arterioscrossis — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (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)

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 April 23 59, to Nov 7 59 and last saw her/him alive on Nov. 7-59
Death occurred at 9 PM m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Wm J Goodson M.D.

22b. ADDRESS: Liberty Mo.

22c. DATE SIGNED: 11-9-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: Nov. 10-59

23c. NAME OF CEMETERY OR CREMATORY: White Chapel Memorial Garden

23d. LOCATION (City, town, or county) (State): Clay Co. Mo.

24. FUNERAL DIRECTOR ADDRESS: D.W. Newcomers Son N.K.C.16,Mo.

25. DATE RECD. BY LOCAL REG.: 11-19-59

26. REGISTRAR'S SIGNATURE: Mabel Graham

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF DOCUMENT

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by m

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed John V. Henick Jr.

Licensed Embalmer No. 4848

P. O. Address P. O. 17 Ma

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.