

**MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-040053**

**FILED VS NOV 17 1959**

149

Primary Registration District No. 1002

Registrar's No.

**5308**

STATE FILE NUMBER

UNRECORDED

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>40 yrs</b>		c. CITY OR TOWN <b>KANSAS CITY</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>2409 E. 27th St.</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>2409 E. 27th St.</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>DAISY</b> Middle Last <b>FORD</b>				4. DATE OF DEATH Month <b>November</b> Day <b>1</b> Year <b>1959</b>					
5. SEX <b>Female</b>	6. COLOR OR RACE <b>N. gro</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 17, 1889</b>	9. AGE (last birthday) <b>70 yrs.</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>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Higginsville, Missouri USA</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>		
13a. FATHER'S NAME <b>Alexander Graham</b>			13b. MOTHER'S MAIDEN NAME <b>Annie Harris</b>			14. NAME OF HUSBAND OR WIFE <b>Ernest Ford</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>No</b>		17. INFORMANT Address <b>Mayme Braskar 2409 E. 27th St. Sister</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>Acute Coronary Occlusion</b> DUE TO (b) <b>Hypertensive Arteriosclerotic Heart Disease</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <b>acute</b>		
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 _____ 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 <b>10/10/59 PM</b> to <b>11/1/59</b> and last saw her him alive on <b>10-28-59</b> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <b>J S Johnson MD</b> (Degree or title)				22b. ADDRESS <b>2202 E. 18th St</b>			22c. DATE SIGNED <b>11-2-59</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>11-5-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Muncie</b>		23d. LOCATION (City, town, or county) <b>Higginsville, Missouri</b>		23e. (State)		
24. FUNERAL DIRECTOR <b>Watkins Bros. Funeral Home 18th &amp; Benton</b>				25. DATE RECD. BY LOCAL REG. <b>11-4-59</b>		26. REGISTRAR'S SIGNATURE <b>Julia Marshall</b>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Johnson

**STATEMENT BY LICENSED EMBALMER**

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

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed \_\_\_\_\_

*Deuce P. Watkins*

Licensed Embalmer No. 4500

P. O. Address 10th & Bea

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.