

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 10 1959

59-040376

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5565

ENDED

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>2 1/2 yrs.</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>none 30 W. 77 Terrace</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>30 W. 77 Terrace</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Gideon</b> Last <b>Sheridan</b>			4. DATE OF DEATH Month <b>November</b> Day <b>16</b> Year <b>1959</b>				
5. SEX <b>male</b>	6. COLOR OR RACE <b>caucasian</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>July 16 1882</b>	9. AGE (last birthday) <b>77</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Carpentry</b>		11. NEAR PLACE (City and state or country) <b>Carthage, Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>James Colts Sheridan</b>			13b. MOTHER'S MAIDEN NAME <b>Dolly Hall Sheridan</b>		14. NAME OF HUSBAND OR WIFE <b>Hattie Elsberry Sheridan</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>498-12-5129A</b>		17. INFORMANT <b>Marvin Sheridan, Hallsville, Mo.</b>			
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 <b>6 hrs</b>	
IMMEDIATE CAUSE (a) <b>Carcinoma prostate - metastatic</b>							
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							
DUE TO (b) <b>to Pelvis &amp; Peritoneum</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. <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 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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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>Oct 59</b> to <b>Nov 16 59</b> and last saw him alive on <b>Nov 16 59</b>			Death occurred at <b>4:10 P</b> m on the date stated above, and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE <b>A W Robinson M.D.</b> (Degree or title)			22b. ADDRESS <b>4635 W. Granite Kc Mo</b>		22c. DATE SIGNED <b>11-17-59</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>11-19-1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Appleman Chapel</b>		23d. LOCATION (City, town, or county) (State) <b>Audrain County, Mo.</b>			
24. FUNERAL DIRECTOR <b>Bill J. Meador, Centralia, Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>11-18-59</b>		26. REGISTRAR'S SIGNATURE <b>Irene Marshall</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF A. W. ROBINSON

46

3 Cert

Copy of [Signature]

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. Coldman

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.