

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 043607

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STATE FILE NUMBER

Registration District No. 4080 Primary Registration District No. 90 Registrar's No.

ENDED

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Carroll</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Norborne</b>		Length of stay in 1b <b>5 Yrs.</b>		c. CITY OR TOWN <b>Norborne</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>204 N. Duncan</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>204 N. Duncan</b>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Sadie</b> Middle <b>Lilly</b> Last <b>Mallory</b>				4. DATE OF DEATH Month <b>Dec.</b> Day <b>23</b> Year <b>1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</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>9 Sept 188</b>	9. AGE (last birthday) <b>71</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <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>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (City and state or country) <b>Norton, Kansas</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Charles H. Moore</b>			13b. MOTHER'S MAIDEN NAME <b>Marie A. Conarty</b>		14. NAME OF HUSBAND OR WIFE <b>Jewell Mallory</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>611-09-2796</b>		17. INFORMANT <b>3500 W. Almond</b> <b>Wm. L. Leighton Kansas City, Mo.</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>Sancer of the Cervix</b>						INTERVAL BETWEEN ONSET AND DEATH <b>6+ months</b>	
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. <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>12-23-59</b> to <b>12-23-59</b> and last saw her alive on <b>12-23-59</b> Death occurred at <b>8:40 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Small - Wallace MD</b>				22b. ADDRESS <b>212 South Pine St Norborne, Mo.</b>		22c. DATE SIGNED <b>12-24-59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>12-24-1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>North Kansas City Mo.</b>		23d. LOCATION (City, town, or county) (State)		
24. FUNERAL DIRECTOR <b>D.W. Newcomers Sons, N.K.P. Mo</b>			ADDRESS <b>12-23-59</b>		25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE <b>Wm. Herbert Chesnut</b>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

JAN 19 1960

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 Ben W. Gibson

Licensed Embalmer No. 2901

P. O. Address Carrollton

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.