

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 44 0 9 4

FILED VS. DEC 21 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5873 STATE FILE NUMBER

UNDECEASED

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kansas City mo</u>		Length of stay in lb <u>3 days</u>	c. CITY OR TOWN <u>Raytown</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) <u>Lakeside</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>6619 Harris</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Dixie</u> Middle <u>Wynne</u> Last <u>Bivins</u>			4. DATE OF DEATH Month <u>December</u> Day <u>5</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 5 1883</u>	9. AGE (last birthday) <u>76</u>	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) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (City and state or country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>USA.</u>	

13a. FATHER'S NAME <u>John Wynne</u>		13b. MOTHER'S MAIDEN NAME <u>Anna Holt</u>		14. NAME OF HUSBAND OR WIFE <u>Deceased</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. —		17. INFORMANT <u>J. W. Warner T. 127 Lake Lot A Wana</u> Address <u>Lee Summit Mo.</u>	

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 <u>3 days</u>
IMMEDIATE CAUSE (a) <u>Acute coronary occlusion</u>			
DUE TO (b) <u>Arteriosclerotic heart disease</u>			
DUE TO (c) _____			

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cardiovascular accident</u>		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	
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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.) <u>Kansas City Jackson Mo.</u>	20f. CITY, TOWN, OR LOCATION <u>Kansas City Jackson Mo.</u>	COUNTY _____ STATE _____
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21. I attended the deceased from Nov 12 1959 to Dec 5, 59 and last saw her alive on Dec 5, 1959
Death occurred at 11:20 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>D. H. Crouch D.O.</u>		22b. ADDRESS <u>2895 East 6 Kansas City 24, Mo</u>		22c. DATE SIGNED <u>12-6-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12/8/1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Kansas City Missouri</u>	

24. FUNERAL DIRECTOR <u>D.W. Newcomers Sons 1331 Brush Creek Blvd.</u>		25. DATE RECD. BY LOCAL REG. <u>12.7.59</u>	26. REGISTRAR'S SIGNATURE <u>Neva Marshall</u>
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Kansas City Missouri (Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

D. H. Crouch

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 Norman W. Holson

Licensed Embalmer No. 4889

P. O. Address H. C. 7/8

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.