

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

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Registration District No. 1009 Primary Registration District No. 1009 Registrar's No. 6109 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE K. C. Mo. b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City, Mo.	Length of stay in 1b 69 years	c. CITY OR TOWN Kansas City, Mo. Jackson	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Northeast Osteopathic		d. STREET ADDRESS (If outside, give location) 3241 Thompson	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First William Middle Emrick Last Emrick			4. DATE OF DEATH Month 12 Day 18 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8-19-1890	9. AGE (last birthday) 69	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Brewery	11. BIRTHPLACE (City and state or country) Kansas City, Mo. Jackson	12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME Frank Emrick		13b. MOTHER'S MAIDEN NAME Emma Breys	14. NAME OF HUSBAND OR WIFE Callie Emrick			

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 499-16-3086	17. INFORMANT Address Frances Deatherage, 3241 Thompson, K.C. Mo.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal pneumonia, pulmonary congestion		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		
DUE TO (b) Cirrhosis of liver, calcification and C.A. at head of pancreas, hepatic obstruction 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	
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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.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE

21. I attended the deceased from **12-4-1959** to **12-17-1959** and last saw ^{her} _{him} alive on **12-17-1959**
 Death occurred at **8.45 A.m** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Dr. E. V. Jones	22b. ADDRESS 3600 2 St. Jackson	22c. DATE SIGNED 12-18-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12/21/1959	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery
24. FUNERAL DIRECTOR ADDRESS Sheil Funeral Home, 6606 Indep. Ave.		23d. LOCATION (City, town, or county) (State) Kansas City Missouri
25. DATE RECD. BY LOCAL REG. 12-19-59		26. REGISTRAR'S SIGNATURE Neva Minshel

DOCUMENT

MEDICAL CERTIFICATION

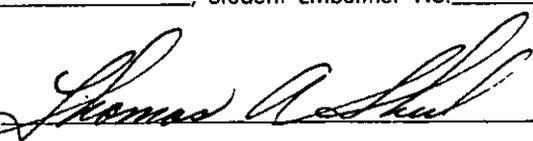
BY AFFIDAVIT OF **E. V. Jones**

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  _____

Licensed Embalmer No. 4954

P. O. Address R. C. 1710

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.