

COURT DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 4 4 1 7 0

FILED VS DEC 21 1959

Registration District No. _____ Primary Registration District No. 1002 Registrar's No. 5743 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 55 yrs.		c. CITY OR TOWN Kansas City		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Mary's Hospital			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS 7301 Sycamore			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First James Middle Roy Last Givens				4. DATE OF DEATH Month Nov. Day 16, Year 1959			
5. SEX male	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 8-23-1885	9. AGE (last birthday) 74	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) retired			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Salina, Kansas		12. CITIZEN OF WHAT COUNTRY U. S. A.
13a. FATHER'S NAME John Wesley Givens			13b. MOTHER'S MAIDEN NAME Wina Mc Call			14. NAME OF HUSBAND OR WIFE Florence R. Givens	
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. 499-14-1382		17. INFORMANT Address Mr. E. M. Lieberman 7309 Sycamore		
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
IMMEDIATE CAUSE (a) hemorrhage							hrs.
DUE TO (b) thrombocytopenia							3 days
DUE TO (c) sub acute lymphatic leukemia							3 mos.
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 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 Nov. 1 -59 to Nov. 16-59 and last saw her/him alive on Nov. 16-59 Death occurred at 8P. m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <i>J. Stewart Whitmore, M.D.</i> (Degree or title)				22b. ADDRESS 101 Memorial Dr. K. C. Mo.			22c. DATE SIGNED 11-17-59
23a. BURIAL / CREMATION, REMAINS (Specify) cremation	23b. DATE 11-18-59	23c. NAME OF CEMETERY OR CREMATORY D. W. Newcomer's Sons		23d. LOCATION (City, town, or county) Kansas City, Mo.		(State)	
24. FUNERAL DIRECTOR D. W. Newcomer's Sons K. C. Mo.			ADDRESS		25. DATE RECD. BY LOCAL REG. Dec. 21 1959	26. REGISTAR'S SIGNATURE <i>Thomas C Durdon</i>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

J. Stewart Whitmore

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. _____

P. O. Address _____

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.