

**MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

'59 0 44 2 1 1

FILED VS. DEC 21 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5823 STATE FILE NUMBER

|   |  |   |  |  |   |  |  |
|---|--|---|--|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Jackson</u>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MO.</u> b. COUNTY <u>Clay</u> |   |  |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>Kansas City</u>   |  | Length of stay in 1b <u>2 yrs</u>   |  | c. CITY OR TOWN <u>Kansas City</u>   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |  |
| c. FULL NAME OF (IF NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>Home 540 Highland</u>   |  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location)<br><u>4441 N. Jackson</u>  |   |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><u>SUSAN ELLA HYLAND</u>  |  |   |  | 4. DATE OF DEATH<br>Month Day Year<br><u>Dec 2, 1959</u>   |   |  |  |
| 5. SEX<br><u>F</u>  | 6. COLOR OR RACE<br><u>W</u>           | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>8-22-1868</u>   | 9. AGE (last birthday)<br><u>91</u>   | IF UNDER 1 YEAR<br>Months Days   | IF UNDER 24 HR<br>Hours Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Homemaker</u>   |  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>None</u>                                     |  | 11. BIRTHPLACE (City and state or country)<br><u>Madison Md</u>                         |  | 12. CITIZEN OF WHAT COUNTRY<br><u>U.S.A.</u>                               |
| 13a. FATHER'S NAME<br><u>John B. Ford</u>   |  |   | 13b. MOTHER'S MAIDEN NAME<br><u>Frances</u>  |  | 14. NAME OF HUSBAND OR WIFE<br><u>George M. Hyland</u>                                  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><u>no</u>  |  |   | 16. SOCIAL SECURITY NO.<br><u>707-07-91810</u>                                       |  | 17. INFORMANT<br><u>Mr. Small Skidmore R.C. 17-40</u><br>Address <u>4441 N. Jackson</u> |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebrovascular Thrombosis</u><br>DUE TO (b) <u>Generalized arteriosclerosis</u><br>DUE TO (c) _____<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |  |   |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH   |
| 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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |  |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour a.m. p.m.<br>Month, Day, Year   |  |   |  |  |   |  |  |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/><br>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 <u>7-4-59</u> to <u>12-2-59</u> and last saw her alive on <u>11-29-59</u><br>Death occurred at <u>10:55</u> <u>A</u> on the date stated above, and to the best of my knowledge, from the causes stated.  |  |   |  |  |   |  |  |
| 22a. SIGNATURE (Degree or title)<br><u>Robert F. Henderson M.D.</u>   |  |   | 22b. ADDRESS<br><u>7228 Beverly Overland Park MO</u>                                 |  |   | 22c. DATE SIGNED<br><u>12-3-59</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Removal</u>   | 23b. DATE<br><u>12-3-59</u>            | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Alliance Cem</u>   |  | 23d. LOCATION (City, town, or county) (State)<br><u>Alliance Mo.</u>   |   |  |  |
| 24. FUNERAL DIRECTOR<br><u>D.W. Newcomer</u>  |  |   | ADDRESS<br><u>M.K.C.</u>   | 25. DATE RECD. BY LOCAL REG.<br><u>12-3-59</u>   | 26. REGISTRAR'S SIGNATURE<br><u>Herb Minshall</u>                                       |  |  |

DOCUMENT

ROBERT F. GOODWIN - MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 Alan W. Hill

Licensed Embalmer No. 4586

P. O. Address K.C. 16, 4

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.