

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

FILED VS JAN 19 1960

STATE FILE NUMBER  
**6270-59-046801**

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6270-59-046801

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Jackson</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in 1b _____		c. CITY OR TOWN <b>Kansas City</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>General Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>7223 Montgall</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
<b>3. NAME OF DECEASED</b> (Type or print) First <b>MARY</b> Middle _____ Last <b>LOVE</b>				<b>4. DATE OF DEATH</b> Month <b>December</b> Day <b>29</b> Year <b>1959</b>									
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>Cauc</b>		<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Sep 18, 1873</b>		<b>9. AGE (last birthday)</b> <b>86</b>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Home</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>Scranton, Pennsylvania</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>USA</b>					
<b>13a. FATHER'S NAME</b> <b>John McCambridge</b>				<b>13b. MOTHER'S MAIDEN NAME</b> <b>Ellen Butler</b>				<b>14. NAME OF HUSBAND OR WIFE</b> <b>William C. Love (Deceased)</b>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>			<b>16. SOCIAL SECURITY NO.</b> <b>NONE</b>			<b>17. INFORMANT</b> Address <b>Mrs Margaret Hedenberg, 7223 Montgall</b>							
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Probable Metastatis carcinoma of brain</b>										INTERVAL BETWEEN ONSET AND DEATH _____			
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			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>			<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)								
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m.		Month, Day, Year _____											
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>			<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)			<b>20f. CITY, TOWN, OR LOCATION</b>		<b>COUNTY</b>		<b>STATE</b>			
<b>21. I attended the deceased from</b> <b>12-23-59</b>				<b>to</b> <b>12-29-59</b>				<b>and last saw her</b> <b>alive</b> <b>on</b> <b>12-29-59</b>					
Death occurred at <b>3:45</b> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.													
<b>22a. SIGNATURE</b> <i>H. Dwyer</i> (Degree or title) <b>M.D.</b>						<b>22b. ADDRESS</b> <b>2400 Cherry K.C. Mo.</b>			<b>22c. DATE SIGNED</b> <b>12-30-59</b>				
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>			<b>23b. DATE</b> <b>Dec 31, 1959</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Calvary Cemetery</b>			<b>23d. LOCATION (City, town, or county)</b> (State) <b>Kansas City, Missouri</b>					
<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>Muehlebach 6800 Troost</b>						<b>25. DATE RECD. BY LOCAL REG.</b> <b>12-30-59</b>		<b>26. REGISTRAR'S SIGNATURE</b> <i>Irene Marshall</i>					

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

H. L. Dwyer

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed R. E. Nichole

Licensed Embalmer No. 4997

P. O. Address K.C. Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.