

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 19 1960

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6274 STATE FILE NUMBER 59-046817

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u> Length of stay in 1b <u>1 day</u>		c. CITY OR TOWN <u>Lees Summit</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph's Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>10408 Sherer</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Virginia K.</u> Middle <u>May</u> Last <u>May</u>			4. DATE OF DEATH Month <u>Dec</u> Day <u>24</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 type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1-19-1892</u>	9. AGE (last birthday) <u>67</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>7</u>	IF UNDER 24 HR Hours <u>0</u> Min. <u>0</u>
----------------------	-------------------------------	---	-----------------------------------	----------------------------------	---	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	11. BIRTHPLACE (City and state or country) <u>Virginia</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
--	---	--	---

13a. FATHER'S NAME <u>John A. Frey</u>	13b. MOTHER'S MAIDEN NAME <u>Clara Belle Waters</u>	14. NAME OF HUSBAND OR WIFE <u>none</u>
--	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If yes, give year or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>494-26-7701</u>	17. INFORMANT <u>James M. May, Lees 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
IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>		<u>8 hrs.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Coronary Atherosclerosis</u>	<u>10 yrs.</u>
	DUE TO (c) <u>Generalized atherosclerosis</u>	<u>10 yrs.</u>

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 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 <u>6:00 pm</u> Month, Day, Year <u>24 Dec 59</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>8:55 pm 24 Dec 59</u>	20f. CITY, TOWN, OR LOCATION <u>Lees Summit</u> COUNTY <u>Mo</u> STATE <u>Mo</u>
---	---	---	--

21. I attended the deceased from <u>6:00 pm 24 Dec 59</u> to <u>8:55 pm 24 Dec 59</u> and last saw her alive on <u>8:54 24 Dec 59</u>	
Death occurred at <u>8:55 p.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.	

22a. SIGNATURE (Degree or title) <u>William C. Van Buskirk M.D.</u>	22b. ADDRESS <u>1418 Professional Bldg - KC Mo</u>	22c. DATE SIGNED <u>30 Dec 59</u>
---	--	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>12-30-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>-</u>	23d. LOCATION (City, town, or county) <u>Shayer, Mo.</u>	23e. STATE <u>Mo.</u>
--	---------------------------	---	--	-----------------------

24. FUNERAL DIRECTOR ADDRESS <u>Carter Mortuary, Shayer, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>12-30-59</u>	26. REGISTRAR'S SIGNATURE <u>nevins minshall</u>
---	--	--

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF WILLIAM C. VAN BUSKIRK, M.D. MEDICAL CERTIFICATION

VS NOV 30 1960

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 John R. Dick

Licensed Embalmer No. 453

P. O. Address Kansas City

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.