

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. JAN 1 9 1960 149

6198-59-046849

Registration District No. _____ Primary Registration District No. 1002 Registrar's No. _____

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Hackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 19 Years	c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" 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 checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2544 Homes Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Frances Middle M. Last Schwartz			4. DATE OF DEATH Dec. 21, 1959 Month Day Year		
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Dec 22, 1879	9. AGE (last birthday) 80	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Wes, Kansas		12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Jacob Schwartz		13b. MOTHER'S MAIDEN NAME Frances Bauer		14. NAME OF HUSBAND OR WIFE None	
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. None		17. INFORMANT Willism J. Schwartz - 2544 Holmes Address	

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 3 days 2 days 10 years 10 years
IMMEDIATE CAUSE (a) Cerebral Concussion from fall			
DUE TO (b) Acute Pulmonary Embolism			
DUE TO (c) Chronic Myocardial Insufficiency			
DUE TO (c) General Arterio Sclerosis			
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 checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) Fell down flight of stairs	
20c. TIME OF INJURY 6:00 P.M. Hour a.m. Month, Day, Year 12-20-59	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.) Home, farm	20f. CITY, TOWN, OR LOCATION Miami Co., Kansas
21. I attended the deceased from 12/20-59 to 12/24-59 and last saw her/him alive on 12/23-59 . Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			

22. SIGNATURE (Degree or title) J. H. O'Connell M.D.		22b. ADDRESS 4178 Cambridge K.C. Mo.		22c. DATE SIGNED 12-24-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 12-26-59	23c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery	23d. LOCATION (City, town, or county) (State) Wes, Kansas	
24. FUNERAL DIRECTOR Melody McGilley-Eylar - 1800 E. Linwood		25. DATE RECD. BY LOCAL REG. 12-25-59	26. REGISTRAR'S SIGNATURE neva mitchell	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF O'Connell

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 William Burtess

Licensed Embalmer No. 4903

P. O. Address R. C. Mo

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.