

UNIFORM DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED 93 JAN 19 1960

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6318-59-046873 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>				2. USUAL RESIDENCE (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 <b>41 years</b>		c. CITY OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <b>3918 Charlotte St. Grosse Nursing Home</b>				d. STREET ADDRESS (If outside, give location) <b>8715 East 77th St.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ruth</b> Middle <b>S.</b> Last <b>Taylor</b>			4. DATE OF DEATH Month <b>Dec.</b> Day <b>29</b> Year <b>1959</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 6/1893</b>	9. AGE (last birthday) <b>66 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Horton Kansas</b>	12. CITIZEN OF WHAT COUNTRY <b>U S A</b>	
13a. FATHER'S NAME <b>Robert James Sandidge</b>			13b. MOTHER'S MAIDEN NAME <b>Laura May Robinson</b>		14. NAME OF HUSBAND OR WIFE <b>John F. Taylor</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>N</b>		16. SOCIAL SECURITY NO. <b>486009-7784</b>	17. INFORMANT Address <b>Mr. John F. Taylor 8715 East 77th St.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Fibrillation</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerotic Heart Disease</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 checked="" type="checkbox"/> N <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 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 <b>6-10-47</b> to <b>12-29-59</b> and last saw her alive on <b>12-28-59</b> Death occurred at <b>9:40 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>L. W. Brumm M.D.</b> (Degree or title)				22b. ADDRESS <b>6308 Troost Ave.</b>			22c. DATE SIGNED <b>DEC 31 59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>1/2/1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mount Moriah Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Kansas City Missouri</b>			
24. FUNERAL DIRECTOR ADDRESS <b>D.W. Newcomers Sons Kansas City, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>1-1-60</b>	26. REGISTRAR'S SIGNATURE <b>Neva Minshel</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

6308  
Linn

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 Norman W. Larson

Licensed Embalmer No. 4889

P. O. Address St. 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.