

# R.I. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-000710

FILED VS. JAN 25 1960

Registration District No. 72 Primary Registration District No. 3013 Registrar's No. 6

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <b>CLAY</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>CLAY</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>NORTH KANSAS CITY</b>		Length of stay in 1b <b>LIFE</b>		c. CITY OR TOWN <b>NORTH KANSAS CITY</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>MEMORIAL HOSP.</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1402 E 24<sup>TH</sup> AVE</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>G.</b> Last <b>CONSOLVER JR.</b>				4. DATE OF DEATH Month <b>1</b> Day <b>8</b> Year <b>60</b>				
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>1-4-1953</b>	9. AGE (last birthday) <b>7</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>KANSAS CITY, MO.</b>		12. CITIZEN OF WHAT COUNTRY	
13a. FATHER'S NAME <b>William G. Consolver</b>			13b. MOTHER'S MAIDEN NAME <b>Althea Litton</b>			14. NAME OF HUSBAND OR WIFE <b>-</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>-</b>			16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>William G. Consolver 1402 E. 24<sup>TH</sup></b>			Address
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>RESPIRATORY FAILURE</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 MOD.</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>CORTICAL VENOUS THROMBOSIS</b>						<b>36 HRS.</b>		
DUE TO (c) <b>U. R. A. EMBOLI</b>						<b>48 HRS.</b>		
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 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>1-7-60</b> to <b>1-8-60</b> and last saw him alive on <b>1-8-60</b> Death occurred at <b>8:45 PM</b> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <b>Therese J. Consolver</b> (Degree or title)			22b. ADDRESS <b>329 Quince Rd. No. 2000</b>			22c. DATE SIGNED <b>1/9/60</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>1-11-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>LOCK SPRINGS Cem</b>		23d. LOCATION (City, town, or county) (State) <b>LOCK SPRINGS MO.</b>				
24. FUNERAL DIRECTOR <b>D.W. Newcomer's Sons N.K.C. Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>1-10-60</b>		26. REGISTRAR'S SIGNATURE <b>Marquette Hudgens</b>			

DOCUMENT

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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed Robert H. Service Jr.  
Licensed Embalmer No. 4848

P. O. Address K. C. 17, W

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.