

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-001368

FILED VS FEB 15 1960

Registration District No. 149 Primary Registration District No. 002 Registrar's No. 557 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 Jackson					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 1 mo.		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 name of HOSPITAL OR INSTITUTION) 3660 Summit Roanoke Nursing Home			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 3636 Summit		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First David Middle I. Last Atkinson				4. DATE OF DEATH Month Jan. Day 30, Year 1960					
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH April 10, 1875	9. AGE (last birthday) 84	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	IF UNDER 24 HR Hours	IF UNDER 24 HR Min.	
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) Retired Farmer			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Kickapoo Kansas		12. CITIZEN OF WHAT COUNTRY U. S. A.		
13a. FATHER'S NAME Thomas Atkinson			13b. MOTHER'S MAIDEN NAME Louisa Swartz			14. NAME OF HUSBAND OR WIFE Anna Atkinson Virginia			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, DO unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. none		17. INFORMANT Catherine Atkinson 3636 Summit				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease							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) Prostatic Hypertrophy with Azotemia						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 _____ 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 January 16, 1960 to January 29, 1960 and last saw her alive on January 29, 1960 Death occurred at 7 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE I. T. Smith M.D. (Degree or title)				22b. ADDRESS 1109 Professional Bldg Kansas City 6 mo.			22c. DATE SIGNED: 1/31/60		
23a. BURIAL, CREMATION, REMOVAL Removal		23b. DATE 1/31/60	23c. NAME OF CEMETERY OR CREMATORY Leavenworth			23d. LOCATION (City, town, or county) (State) Kansas			
24. FUNERAL DIRECTOR Stine & McClure ADDRESS K. C. Mo.			25. DATE RECD. BY LOCAL REG. 1-31-60		26. REGISTRAR'S SIGNATURE Neva Marshall				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Irg T Smith

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 Ornel Roberts

Licensed Embalmer No. 4232

P. O. Address F.C.M.

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