

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-001440

FILED VS FEB 4 1960

149

Registration District No. Primary Registration District No. 1002 Registrar's No. 1

353

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in lb 40 yrs		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 DeLora Nursing Home				d. STREET ADDRESS (If outside, give location) 2000 E 83rd St		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLENE Middle CARPENTER Last CARPENTER				4. DATE OF DEATH Month January Day 18 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>		8. DATE OF BIRTH Jan 13 1880	9. AGE (last birthday) 80	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Holdon Missouri		11. BIRTHPLACE (City and state or country) USA		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Charles Graham			13b. MOTHER'S MAIDEN NAME Katbe Lucus			14. NAME OF HUSBAND OR WIFE _____	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or detes of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Perrin D McElroy Administrator 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) CEREBRAL HEMMORRHAGE DUE TO (b) SENILITY DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH	
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 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 1955 to Jan. 18 '60 and last saw her ^{her} _{last} alive on Jan 17th 1960 Death occurred at 10:40 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE Charles A. Bryant M.D. (Degree or title)				22b. ADDRESS Bldg. K.C. Mo		22c. DATE SIGNED 1-21-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Jan 21 1960	23c. NAME OF CEMETERY OR CREMATORY Forest Hill Cemetery		23d. LOCATION (City, town, or county) (State) Kansas City Missouri		
24. FUNERAL DIRECTOR Shell Funeral Home Kansas City Mo ADDRESS _____				25. DATE RECD. BY LOCAL REG. 1-21-60		26. REGISTRAR'S SIGNATURE Drew Marshall	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF CHARLES A. BRYANT

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 

Licensed Embalmer No. 4954

P. O. Address H.C.M.

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.