

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-001452

FILED VS FEB 4 1960

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 400 STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City, Missouri</u>		c. CITY OR TOWN <u>Kansas City</u>	
Length of stay in 1b <u>13 yrs.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Menorah Medical Center</u>		d. STREET ADDRESS (If outside, give location) <u>7341 Indiana</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>Claude</u> Last <u>CHESNUT</u>			4. DATE OF DEATH Month <u>JANUARY</u> Day <u>23</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11-12-10</u>	9. AGE (last birthday) <u>49 yrs.</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Welder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Black-Smell-Bryson</u>		11. BIRTHPLACE (City and state or country) <u>Salem, Ark</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S. B</u>
13. FATHER'S NAME <u>James M. Chestnut</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Ellenburgess Grace Chestnut</u>		14. NAME OF HUSBAND OR WIFE <u>Grace Chestnut</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>452-09-6988</u>		17. INFORMANT <u>Grace Chestnut, Kansas City, Mo</u> 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
IMMEDIATE CAUSE (a) <u>Acute occlusion, left circumflex coronary artery</u>		<u>10 mins</u>
DUE TO (b) <u>Severe coronary atherosclerosis with old occlusion</u>		<u>2 mo</u>
DUE TO (c) <u>rt. coronary artery and old myocardial infarction, left ventricle</u>		
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 12-4-59 to 1-9-60 and last saw ^{THE}him alive on 1-9-60
Death occurred at 10:30 10 m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>MS</u>	22b. ADDRESS <u>751 E 63 St, KCMO</u>	22c. DATE SIGNED <u>1-24-60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>1-24-60</u>	23c. NAME OF CEMETERY OR CREMATORY _____
24. FUNERAL DIRECTOR <u>Carter Mortuary</u> ADDRESS <u>Salem, Ark</u>	25. DATE RECD. BY LOCAL REG. <u>1-24-60</u>	26. REGISTRAR'S SIGNATURE <u>Reva Minshall</u>

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

S. S. Hoffman 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 John R. E. Eide

Licensed Embalmer No. 453

P. O. Address Kansas City

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.