

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS FEB 15 1960

=60-001457

565 STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 565

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>JACKSON</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u>		Length of stay in 1b <u>40 YRS.</u>		c. CITY OR TOWN <u>KANSAS CITY</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>TRINITY LUTHERAN</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>1111 EAST 8TH</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HATTIE</u> Middle <u>MAY</u> Last <u>CLEVELAND</u>				4. DATE OF DEATH Month <u>JAN.</u> Day <u>29</u> Year <u>1960</u>				
5. SEX <u>FEMALE</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>5-14-1887</u>	9. AGE (last birthday) <u>72</u>	IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u>	IF UNDER 24 HR Hours <u>-</u> Min. <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (City and state or country) <u>NEW LONDON, CONN. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>HORACE DUNBAR</u>			13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		14. NAME OF HUSBAND OR WIFE <u>GEO. H. CLEVELAND</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>NONE</u>		17. INFORMANT <u>OPAL ROSSMAN</u> Address <u>1111 E. 8TH K.C. Mo.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u>							INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>	
Conditions, if any, which gave rise to above cause - (a), stating the underlying cause last. DUE TO (b) <u>Diabetic Coma</u>							<u>Coma</u>	
DUE TO (c) <u>.</u>							<u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>---</u>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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.) <u>-</u>				
20c. TIME OF INJURY Hour <u>-</u> a.m. <u>-</u> p.m.		Month, Day, Year <u>-</u>						
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.) <u>-</u>		20f. CITY, TOWN, OR LOCATION <u>1</u>		COUNTY		STATE
21. I attended the deceased from <u>1-24-60</u> to <u>1-29-60</u> and last saw her alive on <u>1-29-60</u> Death occurred at <u>2:45 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>James E. Walker M.D</u>				22b. ADDRESS <u>1200 Profess Bldg</u>			22c. DATE SIGNED <u>1-30-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>2-1-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BELTON CEM.</u>			23d. LOCATION (City, town, or county) (State) <u>BELTON, MISSOURI</u>		
24. FUNERAL DIRECTOR <u>C. H. BLACKMAN & SON</u> ADDRESS <u>INC. K.C. Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>2-1-60</u>		26. REGISTRAR'S SIGNATURE <u>new minshall</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF
James E. Walker

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 _____

Bert B. Ben

Licensed Embalmer No. 468

P. O. Address H. C. J.

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.