

# R I DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

## =60-001542

### FILED VS JAN 25 1960

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 89 STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Jackson</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Jackson</b>						
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in 1b <b>40 yrs</b>		c. CITY OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>2452 Tracy</b>				d. STREET ADDRESS (If outside, give location) <b>2452 Tracy</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Ben</b> Middle <b>Fitzpatrick</b> Last <b>Fitzpatrick</b>			<b>4. DATE OF DEATH</b> Month <b>January</b> Day <b>3</b> Year <b>1960</b>							
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>Negro</b>	<b>7. Married</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>8-4-05</b>	<b>9. AGE (last birthday)</b> <b>54 yrs</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Porter</b>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Drug Store</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>Galine, Kansas</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U S A</b>			
<b>13a. FATHER'S NAME</b> <b>Unknown</b>			<b>13b. MOTHER'S MAIDEN NAME</b> <b>Unknown</b>			<b>14. NAME OF HUSBAND OR WIFE</b> <b>Katherine Fitzpatrick</b>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> <b>500 14 0232</b>		<b>17. INFORMANT</b> Address <b>Katherine Fitzpatrick 2452 Tracy</b>						
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Thrombosis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Coronary Sclerosis</b> DUE TO (c) <b>Cardiac Hypertrophy</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Arteriosclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			<b>20a. ACCIDENT</b> <input type="checkbox"/>	<b>20b. SUICIDE</b> <input type="checkbox"/>	<b>20c. HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)				
<b>20c. TIME OF INJURY</b> Hour a.m. p.m.		Month, Day, Year		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b>	COUNTY	STATE
<b>21. I attended the deceased from _____ to _____ and last saw her/him alive on _____.</b> Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.										
<b>22a. SIGNATURE</b> <i>Deputy Coroner</i>				<b>22b. ADDRESS</b> <b>1618 Lydon Ave</b>		<b>22c. DATE SIGNED</b> <b>1/4/60</b>				
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE</b> <b>1/15/60</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>LINCOLN CEMETERY</b>		<b>23d. LOCATION</b> (City, town, or county) <b>Kansas City, Mo.</b>					
<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>Lawrence A. Jones Fn. Hm. K. C. No</b>			<b>25. DATE RECD. BY LOCAL REG.</b> <b>1-7-60</b>		<b>26. REGISTRAR'S SIGNATURE</b> <i>Steve Minshall</i>					

DOCUMENT

MEDICAL CERTIFICATION

 BY AFFIDAVIT OF *Hillman*

**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 Millard B. Paul

Licensed Embalmer No. 5013

P. O. Address K.C. Mo.

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.