

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-001548

FILED FEB 15 1960

480

STATE FILE NUMBER

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

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <i>JACKSON</i>	a. STATE <i>Missouri</i> b. COUNTY <i>Platt.</i>		
b. CITY (If outside corporate limits, give TOWNSHIP only) <i>KANSAS CITY</i>	Length of stay in, 1b <i>2-4 yrs.</i>	c. CITY OR TOWN <i>Parkville</i>	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Lideman & McCarty N.H. 3621 WARWICK</i>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <i>RR # 2</i>	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First <i>FRANK</i>	Middle <i>J</i>	Last <i>FLOYD</i>	Month <i>1</i>	Day <i>26</i>	Year <i>1960</i>
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>9-24-79</i>	9. AGE (last birthday) <i>80</i>	IF UNDER 1 YEAR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>farmer</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Haflon West Va.</i>	11. BIRTHPLACE (City and state or country) <i>U.S.A.</i>	12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>
13a. FATHER'S NAME <i>Joseph Floyd</i>	13b. MOTHER'S MAIDEN NAME <i>Mary Stogel</i>	14. NAME OF HUSBAND OR WIFE <i>Mary Floyd</i>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>	16. SOCIAL SECURITY NO. <i>no.</i>	17. INFORMANT <i>Mary Floyd Parkville MO.</i>	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 <i>1 week</i>
IMMEDIATE CAUSE (a) <i>Bronchopneumonia</i>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>usual respiratory disease</i>		
DUE TO (c)		<i>2 wks</i>

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 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 *Jan 1955* to *Jan 26, '60* and last saw him alive on *Jan 20, 1960*.
Death occurred at *8:45 a.m.* on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>H.C. Thurman MD</i>	22b. ADDRESS <i>11 E 1st Parkville, MO</i>	22c. DATE SIGNED <i>1-26-60</i>
23a. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>1-28-60</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Forest Hill</i>
23d. LOCATION (City, town, or county) (State) <i>N.E. MO.</i>		

14. FUNERAL DIRECTOR <i>D.W. Newcome's Sons MO.</i>	ADDRESS <i>N.E.</i>	25. DATE RECD. BY LOCAL REG. <i>1-27-60</i>	26. REGISTRAR'S SIGNATURE <i>newar minshall</i>
--	------------------------	--	--

DOCUMENT

MEDICAL CERTIFICATION

Thurman

BY AFFIDAVIT OF

2 yr.

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 *Albert H. Savage*

Licensed Embalmer No. *4812*

P. O. Address *Hansa at*

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