

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-001590

FILED FEB 15 1960 149

Registration District No. _____ Primary Registration District No. 1002 Registrar's No. 402 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Jackson			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Saline		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 3 weeks	c. CITY OR TOWN Malta Bend		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Mary's Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Rural		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Leona Middle Faye Last Harms			4. DATE OF DEATH Month Jan. Day 24 Year 1960		
5. SEX female	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12-30-59	9. AGE (last birthday) IF UNDER 1 YEAR Months _____ Days 24 IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) unknown		12. CITIZEN OF WHAT COUNTRY U. S. A.
13a. FATHER'S NAME Eugene Harms		13b. MOTHER'S MAIDEN NAME unknown		14. NAME OF HUSBAND OR WIFE none	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. none	17. INFORMANT Hospital Records K. C. Mo.		
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>encephalopathy - hemorrhagic, anoxic</u>					INTERVAL BETWEEN ONSET AND DEATH: 24 days
DUE TO (b) congenital heart - cyanotic type Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. polycythemia secondary DUE TO (c) nephro pathology - secondary to anoxia					
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 Waverly, Mo.		STATE _____
21. I attended the deceased from Jan. 3-60 to Jan. 24-60 and last saw ^{her} him alive on Jan. 24, 60 Death occurred at 12:45P. _____ m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE Geo. W. Wise MD (Degree or title)			22b. ADDRESS Plaza Parkway Bldg.		22c. DATE SIGNED 1-24-60
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE 1-24-60	23c. NAME OF CEMETERY OR CREMATORY -		23d. LOCATION (City, town, or county) (State) Waverly, Mo.
24. FUNERAL DIRECTOR Gibson Funeral Home, ADDRESS Waverly, Mo.		25. DATE RECD. BY LOCAL REG. 1-24-60	26. REGISTRAR'S SIGNATURE Neve Minshall		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF
Geo. W. Wise

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. _____

P. O. Address _____

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.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

congenital heart - cyanotic type

DUE TO (c)

*polycythemia - secondary
nephro-pathology - secondary to anemia*

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.

Yes No Unknown

19. WAS AUTOPSY PERFORMED?
YES NO

20a. ACCIDENT SUICIDE HOMICIDE

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

new record 1-29

20d. INJURY OCCURRED WHILE AT WORK
NOT WHILE AT WORK

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 3 1960* to *Jan 24 1960* and last saw her *Jan 24 1960* alive on *Jan 24 1960*.
Death occurred at *12:45 PM* on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE *Geo W Wore MD* (Degree or title)

22b. ADDRESS *Plaza Parkway Bldg*

22c. DATE SIGNED *1-24-60*

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE *1-24-60*

23c. NAME OF CEMETERY OR CREMATORY

unknown

23d. LOCATION (City, town, or county) (State)

unknown

24. FUNERAL DIRECTOR ADDRESS

Nelson Funeral Home Waverly, Mo.

25. DATE RECD. BY LOCAL REG.

1-24-60

26. REGISTRAR'S SIGNATURE

Neva Minshall

MEDICAL CERTIFICATION

W. WISE

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 _____

James F. Wilson
Licensed Embalmer No. 5076

P. O. Address Carrollton

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.