

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-001605

FILED VS FEB 15 1960

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 540 STATE FILE NUMBER

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</u>		Length of stay in 1b <u>31 Yrs</u>	c. CITY OR TOWN <u>KANSAS CITY</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Northeast Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) <u>134 S 0 Wheelerling</u>
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>CLYDE</u> Middle <u>HEFTON</u> Last <u>HEFTON</u>	4. DATE OF DEATH Month <u>JANUARY</u> Day <u>29</u> Year <u>1960</u>
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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>5-30-1896</u>	9. AGE (last birthday) <u>63</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HR Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>EVANS Electrical</u>	11. BIRTHPLACE (City and state or country) <u>Lebanon MO</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>ELIJAH HEFTON</u>	13b. MOTHER'S MAIDEN NAME <u>Cara Richard</u>	14. NAME OF HUSBAND OR WIFE <u>LIDA HEFTON</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WW1</u>	16. SOCIAL SECURITY NO. <u>490-16-4590</u>	17. INFORMANT <u>Mrs LIDA HEFTON, 134 S 0 Wheelerling</u>
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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>Virus Bronchopneumonia</u>	INTERVAL BETWEEN ONSET AND DEATH <u>4 Days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>—</u> DUE TO (c) <u>—</u>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I <u>Paralysis Agitans</u>	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
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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.)
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20c. TIME OF INJURY Hour <u>—</u> a.m. <u>—</u> p.m. <u>—</u>	Month, Day, Year <u>—</u>
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>KANSAS CITY</u>	COUNTY <u>MO</u>	STATE <u>MO</u>
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21. I attended the deceased from <u>Jan 26, 1960</u> to <u>Jan 29, 1960</u> and last saw him alive on <u>Jan 29, 1960</u> Death occurred at <u>11:30 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <u>Frank E Day R.O.</u>	22b. ADDRESS <u>4314 89th St K.C. Mo</u>	22c. DATE SIGNED <u>1-29-60</u>
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23a. BURIAL OR CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Feb 1, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt Moriah</u>	23d. LOCATION (City, town, or county) (State) <u>KANSAS CITY MO</u>
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24. FUNERAL DIRECTOR <u>Sheil Funeral Home K.C. Mo</u>	ADDRESS <u>1-30-60</u>	25. DATE RECD. BY LOCAL REG. <u>1-30-60</u>	26. REGISTRAR'S SIGNATURE <u>Neer Marshall</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Frank E. Day

**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

*J. Patrick Sheel*

Licensed Embalmer No. 5070

P. O. Address N.C. Me

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.