

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-001661

FILED VS FEB 15 1960 149

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 633

633

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY JACKSON				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY JACKSON									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Length of stay in 1b 50 YEARS		c. CITY OR TOWN KANSAS CITY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 16 E. 34TH TERRACE			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 16 E. 34TH TERRACE		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First MARY Middle FRANCES Last KELLEY				4. DATE OF DEATH Month FEBRUARY Day 1 Year 1960									
5. SEX FEMALE		6. COLOR OR RACE CAUCASIAN		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH MAY 6 1867		9. AGE (last birthday) 92		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC			11. BIRTHPLACE (City and state or country) KNOXVILLE KENTUCKY			12. CITIZEN OF WHAT COUNTRY U.S.A.				
13a. FATHER'S NAME THOMAS TROSPER				13b. MOTHER'S MAIDEN NAME UNKNOWN				14. NAME OF HUSBAND OR WIFE JOHN H. KELLEY (DECEASED)					
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 Mrs GEORGE HUTTON 16 E 34TH TERR				Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-sclerotic Heart Disease										INTERVAL BETWEEN ONSET AND DEATH 2 years			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Rheumatoid Arthritis								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.)									
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.) 1650		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE					
21. I attended the deceased from 1950 to Feb 1, 1960 and last saw her Feb 1, 1960 alive on _____ Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE Robert Jansen M.D. (Degree or title)				22b. ADDRESS 101 E 63rd St				22c. DATE SIGNED 2-2-60					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE Feb. 4, 1960		23c. NAME OF CEMETERY OR CREMATORY MOUNT WASHINGTON CEM.			23d. LOCATION (City, town, or county) (State) KANSAS CITY, MISSOURI						
24. FUNERAL DIRECTOR MUEHLEBAEH 6800 TROOST				25. DATE RECD. BY LOCAL REG. Feb. 3, 1960		26. REGISTRAR'S SIGNATURE Neva Minshall							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF Robert Jansen

Dr. R. L. Jones

101 E. 4th St

EA 1

2:00 - 5:00 P.M. Tues

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____, Student Embalmer No. _____, working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *A. E. Nichols*

Licensed Embalmer No. *4997*

P. O. Address *K. P. W.*

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.