

# FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-001831

FILED VS FEB 1 1960 Primary Registration District No. 1.002 Registrar's No. 233 STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. 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>62 years</b> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>V A HOSPITAL</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>Jackson</b> c. CITY OR TOWN <b>KANSAS CITY</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <b>1109 WEST 77TH TERR</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>BERNARD</b> Middle <b>PAUL</b> Last <b>RAMEY</b>			<b>4. DATE OF DEATH</b> Month <b>January</b> Day <b>13</b> Year <b>1960</b>				
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>2-11-97</b>	<b>9. AGE</b> (last birthday) <b>62</b> IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Office manager, retired</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> Galloway, Missouri		<b>11. BIRTHPLACE</b> (City and state or country) <b>U.S.A.</b> <b>12. CITIZEN OF WHAT COUNTRY</b>			
<b>13a. FATHER'S NAME</b> <b>Lynn Ramey</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>Lucille Hendrix</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>Lucille Ramey</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes WWII &amp; WWII</b>		<b>16. SOCIAL SECURITY NO.</b> <b>489 34 9757</b>		<b>17. INFORMANT</b> Address <b>Kansas City, Mo</b> <b>Mrs. Lucille A. Ramey 1109 W. 77th Terr</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>Bronchopneumonia, R&amp;LLL</b> DUE TO (b) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) <b>Meningioma, left</b> 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				INTERVAL BETWEEN ONSET AND DEATH			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>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</b> <u>July 10, 1959</u> to <u>January 13, 1960</u> <sup>her</sup> <del>last</del> <del>known</del> <del>place</del> Death occurred at <u>7:58 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> <i>J.A. Turner</i> (Degree or title) <b>M.D.</b>			<b>22b. ADDRESS</b> <b>VA Hospital, Kansas City, Mo.</b>		<b>22c. DATE SIGNED</b> <b>1-14-60</b>		
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>		<b>23b. DATE</b> <b>JAN 16, 1960</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>MT. OLIVET CEM</b>		<b>23d. LOCATION</b> (City, town, or county) (State) <b>KANSAS CITY MO.</b>		
<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>D.W. NEWCOMER'S SONS K.C.MO.</b>			<b>25. DATE RECD. BY LOCAL REG.</b> <b>1-14-60</b>		<b>26. REGISTRAR'S SIGNATURE</b> <i>neva minshall</i>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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**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 Kansas City

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.