

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS FEB 15 1960

-60-001841

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STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 002 Registrar's No. 660

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Saline</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kansas City</u>		Length of stay in 1b <u>3 months</u>		c. CITY OR TOWN <u>Slater</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>101 E 36th Str</u>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Slater Missouri</u>		
3. NAME OF DECEASED (Type or print) First <u>Sadie Belle</u> Middle <u>Ricard</u> Last <u>Ricard</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>2</u> Year <u>1960</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>3-25-1890</u>		
9. AGE (last birthday) <u>79</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HR Hours <u> </u> Min. <u> </u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>		11. BIRTHPLACE (City and state or country) <u>California, Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Arson Parker</u>			13b. MOTHER'S MAIDEN NAME <u>Unknown</u>			13c. NAME OF HUSBAND OR WIFE <u>Arthur P Ricard</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>F. Ricard, 1171 E 65th Kansas City, Mo</u>			
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>Pneumonia</u> DUE TO (b) <u>G.A.S. + Serebity..</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>2 yrs -</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Pylonephritis.</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		
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.) <u> </u>				
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u>		Month, Day, Year <u> </u> <u> </u> <u> </u>		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.) <u> </u>		
20f. CITY, TOWN, OR LOCATION <u> </u>		COUNTY <u> </u>		STATE <u> </u>				
21. I attended the deceased from <u>1 Jan 60 -</u> to <u>2-2-60</u> and last saw her alive on <u>1 Jan 60</u> Death occurred at <u>2 Jan 60 8:30 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>Burton Lambert MD</u> (Degree or title)				22b. ADDRESS <u>4000 Baltimore K C Mo</u>		22c. DATE SIGNED <u>3 Jan 60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>2-3-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u> </u>		23d. LOCATION (City, town, or county) (State) <u>Slater Missouri</u>		
24. FUNERAL DIRECTOR <u>Haines Mortuary Slater Mo</u>			25. DATE RECD. BY LOCAL REG. <u>2-4-60</u>		26. REGISTRAR'S SIGNATURE <u>Neva Minshall</u>			

DOCUMENT

BY AFFIDAVIT OF SUPPORT CASEBORN MEDICAL CERTIFICATION

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

John R. Sid
Licensed Embalmer No. 453
P. O. Address Kansas

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