

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-001927

FILED VS FEB 15 1960

149

Primary Registration District No. 1002

Registrar's No.

507

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. 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>12 Yrs.</b>		c. CITY OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>New Hope Nursing Home</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>922 Linwood Blvd.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>DORA</b> Middle <b>BROWN</b> Last <b>STRAIN</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>28,</b> Year <b>1960</b>						
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>6-1-1873</b>	9. AGE (last birthday) <b>86</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Cherokee, Kansas</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>			
13a. FATHER'S NAME <b>George Brown</b>			13b. MOTHER'S MAIDEN NAME <b>Anna Butler</b>			14. NAME OF HUSBAND OR WIFE <b>Cyrus W. Strain</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Robert L. Strain</b> Address <b>Kansas City, Mo.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2-3 days</b>			
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)						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		COUNTY		STATE		
21. I attended the deceased from <b>Jan 27<sup>th</sup>, 1960</b> to <b>1-28-60</b> and last saw her/him alive on <b>Jan 27<sup>th</sup>, 1960</b> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.										
22a. SIGNATURE <b>[Signature]</b> (Degree or title) <b>M.D.</b>				22b. ADDRESS <b>815 Schubert Bldg</b>				22c. DATE SIGNED <b>1-28-60</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>1-28-60</b>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) <b>Cherokee, Kansas</b>		(State)		
24. FUNERAL DIRECTOR <b>Freeman Mortuary</b> ADDRESS <b>Kansas City, Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>1-28-60</b>		26. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

*S. L. ...*

**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. H. Freeman*

Licensed Embalmer No. 29  
P. O. Address F. O. ...

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.