

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-001933

FILED VS FEB 15 1960

530

STATE FILE NUMBER

Registration District No. 49 Primary Registration District No. 1002 Registrar's No.

1. PLACE OF DEATH a. COUNTY <i>Jackson</i>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Mo.</i> b. COUNTY <i>Jackson</i>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Kansas City</i>		Length of stay in lb <i>8 yr.</i>		c. CITY OR TOWN <i>Kansas City</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Newwood Nursing Home</i>			Include Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <i>129 N. White</i>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <i>Emma</i> Middle <i>Gertrude</i> Last <i>Sutton</i>				4. DATE OF DEATH Month <i>Jan</i> Day <i>28</i> Year <i>1960</i>					
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <i>4-5-1872</i>			
9. AGE (last birthday) <i>87</i>		IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>		IF UNDER 24 HR Hours <i>0</i> Min. <i>0</i>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Horsewife</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>at Home</i>		11. BIRTHPLACE (City and state or country) <i>McComb, Ill.</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>		
13a. FATHER'S NAME <i>Jared Keonse</i>			13b. MOTHER'S MAIDEN NAME <i>Mary Suell</i>			14. NAME OF HUSBAND OR WIFE <i>Albert Sutton</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT <i>Ms. Margaret Hansen</i>			Address <i>2318 Buinotte K.C. Mo.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> DUE TO (b) <i>Acute enteritis</i> DUE TO (c) <i>-</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <i>one day</i> <i>three days</i>		
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"/> N. <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 <i>-</i> a.m. <i>-</i> 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 <i>1957</i> , to <i>Jan. 28, 1960</i> and last saw her <i>her</i> alive on <i>Jan. 28, 1960</i> Death occurred at <i>2:40 P.M.</i> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <i>G. Lynn W. Springer, D.O.</i>				22b. ADDRESS <i>5902 St. John ave. Kansas City, Mo.</i>		22c. DATE SIGNED <i>1-29-60</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		23b. DATE <i>1-31-1960</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Deepwater Cem.</i>		23d. LOCATION (City, town, or county) <i>Deepwater Mo.</i>		(State)	
24. FUNERAL DIRECTOR <i>C.H. Blackman &amp; Son Inc. K.C. Mo.</i>				ADDRESS <i>1-29-60</i>		25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE <i>Neva Minshall</i>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

G. Lynn W. Springer

**STATEMENT BY LICENSED EMBALMER**

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

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed W.C. Quinn

Licensed Embalmer No. 4879

P. O. Address N.C. 716

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.