

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-001972

FILED VS. FEB. 15 1960 149

Primary Registration District No. 1002 Registrar's No. 590

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) Kansas City | | Length of stay in 1b 11yrs | | 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) St. Lukes Hospital | | | | d. STREET ADDRESS 3701 Broadway | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) Katherine Webber | | | 4. DATE OF DEATH Month 1 Day 30 Year 1960 | | | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 7-17-1894 | 9. AGE (last birthday) 65 | | IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sect. | | | 10b. KIND OF BUSINESS OR INDUSTRY office | | 11. BIRTHPLACE (City and state or country) Topeka, Kansas | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13a. FATHER'S NAME Unknown | | | 13b. MOTHER'S MAIDEN NAME Unknown | | | 14. NAME OF HUSBAND OR WIFE Mrs. John Mayer | | |
| 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. 486-09-8848 | | 17. INFORMANT Mrs. John Mayer Address 3701 Broadway, 829 W. 55th St. E. Mo | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction Arterio sclerotic heart Disease 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 | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 days | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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 1-28-60 to 1-30-60 and last saw her/him alive on 1-30-60 Death occurred at 11:04 a.m. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE (Degree or title) M. Donald M. Farland M.D. | | | | 22b. ADDRESS 315 Nichols Rd K.C. 12 Mo | | 22c. DATE SIGNED 2/1/60 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE 2-2-1960 | 23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery Topeka, Kansas | | 23d. LOCATION (City, town, or county) (State) | | | | |
| 24. FUNERAL DIRECTOR Melody-McGilley-Eylar 20 W. Linwood Kansas City 11, Mo | | | | 25. DATE RECD. BY LOCAL REG. 2-1-60 | | 26. REGISTRAR'S SIGNATURE Mrs. Marshall | | |

DOCUMENT

BY AFFIDAVIT OF M. Donald M. Farland M.D. MEDICAL CERTIFICATION

(Sensed Embalmer's Statement on Reverse Side)

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 _____

Wm H. Lentz

Licensed Embalmer No. 5038

P. O. Address K. E. M.

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