

**MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-005514**

**FILED VS FEB 17 1960**

STATE FILE NUMBER

Registration District No. 71 Primary Registration District No. 3012 Registrar's No. 14

UNRECORDED

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Clay</u>			<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clay</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Excelsior Springs</u>		Length of stay in 1b years <u>          </u>	c. CITY OR TOWN <u>Excelsior Springs</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Excelsior Hospital</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>601 North Main</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Arthur</u> Middle <u>          </u> Last <u>Jenkins</u>			<b>4. DATE OF DEATH</b> Month <u>February</u> Day <u>3</u> Year <u>1960</u>					
<b>5. SEX</b> <u>male</u>	<b>6. COLOR OR RACE</b> <u>Negro</u>	<b>7. Married</b> <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>2-14-1897</u>	<b>9. AGE</b> (last birthday) <u>62</u>	<b>IF UNDER 1 YEAR</b> Months <u>          </u> Days <u>          </u>		<b>IF UNDER 24 HR</b> Hours <u>          </u> Min. <u>          </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>retired mechanic</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>automobile</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>Parkville, Mo.</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A.</u>		
<b>13a. FATHER'S NAME</b> <u>Charlie Jenkin</u>			<b>13b. MOTHER'S MAIDEN NAME</b> <u>Lydia Conley</u>		<b>14. NAME OF HUSBAND OR WIFE</b> <u>unknown</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>	<b>17. INFORMANT</b> Address <u>Mrs Lydia Riffe, Excelsior Springs, Mo</u>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:						<b>INTERVAL BETWEEN ONSET AND DEATH</b>		
IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u>						<u>6 days</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.								
DUE TO (b) <u>Hypertension</u>								
DUE TO (c) <u>Arteriosclerosis</u>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Obesity</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		
<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 <u>          </u> a.m. <u>          </u> p.m.	Month, Day, Year <u>          </u>							
<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>1-29-60</u> to <u>3 Feb '60</u> and last saw <u>him</u> alive on <u>3 Feb '60</u> Death occurred at <u>1:15 p.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.								
<b>22a. SIGNATURE</b> (Degree or title) <u>George E Sanders M.D.</u>				<b>22b. ADDRESS</b> <u>Excelsior Springs, Mo.</u>		<b>22c. DATE SIGNED</b> <u>2-4-60</u>		
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE</b> <u>2-5-60</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Elmwood</u>		<b>23d. LOCATION</b> (City, town, or county) (State) <u>Excelsior Springs, Missouri</u>			
<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>Prichard Funeral Home, Excelsior Springs,</u>			<b>25. DATE RECD. BY LOCAL REG.</b> <u>2/10/60</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>Baroline Hutchings</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 Ralph Van Landingham

Licensed Embalmer No. 4009

Indian Springs, Fla.  
City Address

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.