

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) OR TOWN Kansas City		Length of stay in 1b 39 years	c. CITY OR TOWN Kansas City Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1918 Waldron		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1918 Waldron Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Clarence Middle Albert Last Dorrell			4. DATE OF DEATH Month February Day 8 Year 1960	
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5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Married Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2/11/1892	9. AGE (last birthday) 67-68	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Plumber		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Arkansas	12. CITIZEN OF WHAT COUNTRY U S A
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13a. FATHER'S NAME John Dorrell		13b. MOTHER'S MAIDEN NAME Isabell Langwell		14. NAME OF HUSBAND OR WIFE Edna Florence Dorrell	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. 491 -20-1738	17. INFORMANT Mrs. Edna Florence Dorrell Address 1918 Waldron Kansas City
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH 3740 years
IMMEDIATE CAUSE (a) Myocardial failure			
DUE TO (b) Nephritis & hypert.			
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 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.)	
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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
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21. I attended the deceased from Jan 20-60 to 2/8/60 and last saw her alive on 2/7/60 Death occurred at 7:15 PM on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE (Degree or title) C. Trippe M.D.		22b. ADDRESS 6247 Brookside Blvd		22c. DATE SIGNED 2/8/60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2/11/1960	23c. NAME OF CEMETERY OR CREMATORY Forest Hill Cemetery	23d. LOCATION (City, town, or county) (State) Kansas City Missouri
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24. FUNERAL DIRECTOR ADDRESS D.W. Newcomers Sons 1331 Brush Creek Blvd.		25. DATE RECD. BY LOCAL REG. 2-9-60	26. REGISTRAR'S SIGNATURE Reva Minshall
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DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF: **C. Trippe**

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

Chester Brown

Licensed Embalmer No. 493

P. O. Address S E No

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