

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAR 3 1960

-60-006276

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 886 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <i>Jackson</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Kansas</i> b. COUNTY <i>Wyandotte</i>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Kansas City</i>		Length of stay in lb <i>3 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 INSTITUTE <i>K.C. Convalescent Home</i>			Outside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <i>5546 Lathrop</i>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Andrew</i> Middle <i>Lee</i> Last <i>Samble</i>				4. DATE OF DEATH Month <i>2</i> Day <i>12</i> Year <i>1960</i>				
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <i>7-13-1869</i>	9. AGE (last birthday) <i>90</i>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>farmer</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Self</i>		11. BIRTHPLACE (City and state or country) <i>Missouri</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13a. FATHER'S NAME <i>Unknown</i>			13b. MOTHER'S MAIDEN NAME <i>Unknown</i>			14. NAME OF HUSBAND OR WIFE <i>Iva M. Samble</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>Mr. Dorothy Cooper</i>			Address <i>3424 E. 6th 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>Acute Bilateral Pneumonitis</i>							INTERVAL BETWEEN ONSET AND DEATH <i>48 hr.</i>	
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) <i>Acute Bacterial Parotiditis on left</i>					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 _____ 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 <i>Feb 12, 1960</i> to <i>Feb 12, 60</i> and last saw her alive on <i>Feb 12, 1960</i> Death occurred at <i>11:30 pm</i> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (In green or blue) <i>Robert L. Ward, M.D.</i>				22b. ADDRESS <i>4126 St John</i>			22c. DATE SIGNED <i>2-13-60</i>	
23. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		23b. DATE <i>2/13/1960</i>	23c. NAME OF CEMETERY OR CREMATORY <i>—</i>		23d. LOCATION (City, town, or county) (State) <i>Newark, Arkansas</i>			
24. FUNERAL DIRECTOR <i>C.H. Blackman + Son Inc. K.C.Mo. 2-14-60</i>			25. DATE RECD. BY LOCAL REG. <i>Feb 13, 1960</i>		26. REGISTRAR'S SIGNATURE <i>Mrs Marshall</i>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Robert L. Ward

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 W.C. Rennie

Licensed Embalmer No. 4879

P. O. Address K.C., Mo.

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.