

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-006320

FILED VS. MAR. 7 1960

149

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

1102

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in 1b <b>75 yrs</b>	c. CITY OR TOWN <b>Kansas City</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Grosse Nurs.Home</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>200 West 50th St.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>DELIA</b> Middle Last <b>HARRINGTON</b>			4. DATE OF DEATH Month <b>2</b> Day <b>22</b> Year <b>60</b>
5. SEX <b>Fe</b>	6. COLOR OR RACE <b>Wh</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>11-2-69</b>
9. AGE (last birthday) <b>90</b>		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) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (City and state or country) <b>Ireland</b>
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13a. FATHER'S NAME <b>Frank O'Brien</b>	
13b. MOTHER'S MAIDEN NAME <b>Mary Owens</b>		14. NAME OF HUSBAND OR WIFE <b>Wm.C.Harrington</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>xx</b> (If yes, give war or dates of service) <b>xx</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>Frank E.Harrington, 106 E.50th St.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Cordein Failure</b> DUE TO (b) <b>Hypertension and Arteriosclerosis</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b> <b>17+</b>
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 checked="" type="checkbox"/> No <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 <b>April 5 1943</b> to <b>Feb 20 1960</b> and last saw her alive on <b>Feb 20 1960</b> Death occurred at <b>10:10 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Frank B. Leitz MD</b>		22b. ADDRESS <b>1530 Prof Bldg Kansas City, Mo</b>	22c. DATE SIGNED <b>2-24-60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>2-25-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt.St.Mary's Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Kansas City, Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Wagner Funeral Home. K &amp; Mo</b>		25. DATE RECD. BY LOCAL REG. <b>2-24-60</b>	26. REGISTRAR'S SIGNATURE <b>Neva Minshall</b>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF Frank B. Leitz

**STATEMENT BY LICENSED EMBALMER**

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

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

Signed Alvin R. Hausch

Licensed Embalmer No. 4159

P. O. Address. H. E. M.

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.