

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS FEB 20 1960 / yjr

-60-006324

Registration District No. _____ Primary Registration District No. 1002 Registrar's No. 725 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Jackson			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in lb 12 yrs		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) HOSPITAL OR INSTITUTION 8030 Walrond		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS 8030 Walrond (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MERNIE Middle DOROTHY Last HARVEY			4. DATE OF DEATH Month 2 Day 6 Year 60		
5. SEX Fe	6. COLOR OR RACE Wh	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9-8-81	9. AGE (last birthday) 78	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (City and state or country) New York State	
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME Joel Jewel Clark		13b. MOTHER'S MAIDEN NAME Dorothy Minor	
14. NAME OF HUSBAND OR WIFE Jesse Harvey		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. None	
17. INFORMANT Mr. Wm. Harvey, 8030 Walrond		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 2 hours	
DUE TO (b) Arteriosclerotic Heart Disease		DUE TO (c) _____		2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I. (a) Cerebral Hemorrhage 2 years ago.		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 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 checked="" 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 Aug 1, 1957 to Feb. 6, 1960 and last saw her Feb 6, 1960 alive on _____ Death occurred at 11: P.M. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE John K. Caldwell MD (Degree or title)		22b. ADDRESS Kansas City, Mo.		22c. DATE SIGNED 2/8/60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2-9-60		23c. NAME OF CEMETERY OR CREMATORY Mt. Moriah Cem.	
23d. LOCATION (City, town, or county) Kansas City		23e. (State) Mo.			
24. FUNERAL DIRECTOR Wagner Funeral Home. K.C. Mo		25. DATE RECD. BY LOCAL REG. 2-8-60		26. REGISTRAR'S SIGNATURE Wm. Minshall	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF
John K. Caldwell

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 Neal William Davis

Licensed Embalmer No. 4195

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.