

R DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-006354

FILED VS MAR 7 1960

149

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

1105

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>KANSAS</b> b. COUNTY <b>RUSSELL</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		Length of stay in 1b <b>5 DAYS</b>	c. CITY OR TOWN <b>RUSSELL</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>CRESTWOOD MED CEN.</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>635 SUNSET</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>MATHILDA WILHELMINA</b> Middle <b>HUNTER</b> Last _____			4. DATE OF DEATH Month <b>FEB</b> Day <b>20</b> Year <b>1960</b>		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</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>MAY 21, 1884</b>	9. AGE (last birthday) <b>75 yrs.</b>	IF UNDER 1 YEAR Months _____ Days _____
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>NEB</b>		11. BIRTHPLACE (City and state or country) <b>USA</b>	
13a. FATHER'S NAME <b>MATTHIAS ZELLER</b>		13b. MOTHER'S MAIDEN NAME <b>ROSINA BUSCH BUSCH</b>		14. NAME OF HUSBAND OR WIFE <b>A A HUNTER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT Address <b>CARL E. ZELLER SPRINGFIELD MO.</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>PULMONARY EDEMA</b>					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>MYOCARDITIS AND VALVULAR FAILURE</b> DUE TO (c) <b>GASTRO INTEST. HEMMORHAGE CAUSE UNKNOWN</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>CANCER OF LEFT BREAST MALNUTRITION</b>				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.)			
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____					
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>12 7 59</b> to <b>2 20 60</b> and last saw her/him alive on <b>2 19 60</b> Death occurred at <b>10.15 AM</b> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>Debra M. Newcomer</i>			22b. ADDRESS <b>1410 CENTRAL ST. K. C. MO.</b>		22c. DATE SIGNED <b>2-24-60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>	23b. DATE <b>2 24 60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>B. W. NEWCOMER'S SONS</b>		23d. LOCATION (City, town, or county) (State) <b>KANSAS CITY MO.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>D. W. NEWCOMER'S SONS K.C.MO.</b>			25. DATE RECD. BY LOCAL REG. <b>2-24-60</b>	26. REGISTRAR'S SIGNATURE <i>Debra M. Newcomer</i>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF, Debra M. Newcomer

**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 *Opeta K Brown*

Licensed Embalmer No. 493  
P. O. Address RE [unclear]

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.