

**FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-006430**

**FILED VS. FEB 23 1960**

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 732

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>Missouri</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>34 yrs.</b>		c. CITY OR TOWN <b>Kansas City</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>General Hospital # 1</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>414 Highland</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>F.</b> Last <b>Madison</b>				4. DATE OF DEATH Month <b>2</b> Day <b>7</b> Year <b>60</b>				
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>9-2-1880</b>	9. AGE (last birthday) <b>79</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>Janitor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Avey Apt.</b>		11. BIRTHPLACE (City and state or country) <b>Strawberry Arkansas</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A</b>		
13a. FATHER'S NAME <b>Robert Madison(d)</b>			13b. MOTHER'S MAIDEN NAME <b>Isabel Hodges (D)</b>		14. NAME OF HUSBAND OR WIFE <b>Hannah Madison</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>487-05-2337</b>		17. INFORMANT Address <b>Hannah Madison 414 Highland</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>Pneumonia - (Terminal)</b>						INTERVAL BETWEEN ONSET AND DEATH		
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)					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 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>2-6-60</b> to <b>2-7-60</b> and last saw <del>xx</del> him alive on <b>2-7-60</b> Death occurred at <b>7:00am</b> <b>2-7-1960</b> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <b>H. L. Dwyer</b> (Degree or title)			22b. ADDRESS <b>M.D. 2400 Cherry City</b>			22c. DATE SIGNED <b>2-8-60</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>2-9-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Forest Hill</b>		23d. LOCATION (City, town, or county) (State) <b>Kansas City, Mo.</b>			
24. FUNERAL DIRECTOR <b>H. L. Earp &amp; Sons, Kansas City, Mo.</b> ADDRESS			25. DATE RECD. BY LOCAL REG. <b>2-8-60</b>		26. REGISTRAR'S SIGNATURE <b>Neve Minshall</b>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 William H. Eay

Licensed Embalmer No. 4728

P. O. Address H. C. M.

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