

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-006655

FILED VS MAR 7 1960

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1066 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>Missouri</i> b. COUNTY <i>Jackson</i> | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Kansas City</i> | | Length of stay in 1b <i>61 yrs</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 INSTITUTION <i>General Hospital</i> | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <i>802 Tracy</i> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <i>KATHRYN E VEACH</i> | | | | 4. DATE OF DEATH Month Day Year <i>2 20 60</i> | | | | |
| 5. SEX <i>Fe</i> | 6. COLOR OR RACE <i>Wh</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>7-23-74</i> | 9. AGE (last birthday) <i>85</i> | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>XX</i> | | 11. BIRTHPLACE (City and state or country) <i>Paola, Kansas</i> | | 12. CITIZEN OF WHAT COUNTRY <i>USA</i> | | |
| 13a. FATHER'S NAME <i>William W. Fox</i> | | | 13b. MOTHER'S MAIDEN NAME <i>Sarah Jane Garrett</i> | | | 14. NAME OF HUSBAND OR WIFE <i>George W. Veach</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>None</i> | | 17. INFORMANT <i>Self</i> Address | | | | |
| 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>Cerebral Vascular Accident</i> | | | | | | | 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 <i>1-30-60</i> to <i>2-20-60</i> and last saw her ^{him} alive on <i>2-20-60</i> Death occurred at <i>10:50 p.m.</i> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE <i>H. Dwyer</i> (Degree or title) | | | | 22b. ADDRESS | | 22c. DATE SIGNED <i>2-20-60</i> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i> | | 23b. DATE <i>2-23-60</i> | 23c. NAME OF CEMETERY OR CREMATORY <i>Gardner Kansas Cem.</i> | | 23d. LOCATION (City, town, or county) <i>Gardner, Kansas</i> | | (S) (e) | |
| 24. FUNERAL DIRECTOR <i>Magner Funeral Home</i> ADDRESS | | | 25. DATE RECD. BY LOCAL REG. <i>2-22-60</i> | | 26. REGISTRAR'S SIGNATURE <i>Neva Marshall</i> | | | |

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.