

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-009967

FILED VS APR 11 1960

042 Primary Registration District No. 1000 Registrar's No. 424

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Buchanan			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in 1b 5 years	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 State Hospital #2		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4429 Jarboe		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MARY Middle EILEEN Last HINES			4. DATE OF DEATH Month April Day 2, Year 1960		
5. SEX Female	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 3-29-1914	9. AGE (last birthday) 46
				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) waitress		10b. KIND OF BUSINESS OR INDUSTRY Restaurant	11. BIRTHPLACE (City and state or country) Springfield, Illinois		12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Edward Hainsel		13b. MOTHER'S MAIDEN NAME not given		14. NAME OF HUSBAND OR WIFE Richard N. Hines	
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 Richard N. Hines, 4429 Jarboe, K.C. Mo.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Choked to death by a piece of meat					INTERVAL BETWEEN ONSET AND DEATH 10 min.
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) ChroBrain Syndrome associated with central nervous system--syphilitic meningo-encephales				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 checked="" 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.) Choked on piece of meat while eating dinner			
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.) dining room, State Hosp, St. Joseph	20f. CITY, TOWN, OR LOCATION St. Joseph	COUNTY Missouri	STATE Missouri	
21. I attended the deceased from April 2 only to Present at death and last saw her alive on April 2, 1960 Death occurred at 11 A m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Forrest Thomas MD			22b. ADDRESS State Hospital #2, St. Joseph		22c. DATE SIGNED 4/2/60
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Apr. 4, 1960	23c. NAME OF CEMETERY OR CREMATION Memorial Park	23d. LOCATION (City, town, or county) Kansas City	STATE Missouri	
24. FUNERAL DIRECTOR D.W. Newcomer's Sons, Kansas City, Mo			25. DATE RECD. BY LOCAL REG. April 8, 1960	26. REGISTRAR'S SIGNATURE Mrs. Clark Landell	

DOCUMENT

BY AFFIDAVIT OF F. Thomas, M.D. MEDICAL CERTIFICATION

**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 *[Handwritten Signature]*

Licensed Embalmer No. 646

P. O. Address *[Handwritten Address]*

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