

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-010845

FILED VS. APR. 1 1960

149

Primary Registration District No. 1002

Registrar's No.

1626

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Length of stay in 1b <u>60 yrs.</u>	c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Gen Hosp. # 1</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>2605 Nicholson</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>M.</u> Last <u>Cass</u>			4. DATE OF DEATH Month <u>3</u> Day <u>18</u> Year <u>60</u>			
5. SEX <u>m</u>	6. COLOR OR RACE <u>w</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9-22-1895</u>	9. AGE (last birthday) <u>64</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____	IF UNDER 24 HR Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>truck driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lumber</u>		11. BIRTHPLACE (City and state or country) <u>Rogers, Ark.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S.</u>
13a. FATHER'S NAME <u>Aaron Cass</u>		13b. MOTHER'S MAIDEN NAME <u>Melissa Lloyd</u>		14. NAME OF HUSBAND OR WIFE <u>Minnie Cass</u>		

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>496-05-9857</u>	17. INFORMANT <u>Minnie Cass</u>	Address <u>2605 Nicholson</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pending Autopsy - mycosis fungoid</u>		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	
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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 <u>_____</u>	COUNTY <u>_____</u>	STATE <u>_____</u>
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21. I attended the deceased from 2-16-60 to 3-18-60 and last saw ^{her}/_{him} alive on 3-18-60
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>W. Dwyer</u> (Degree or title)	22b. ADDRESS <u>2400 Cherry</u>	22c. DATE SIGNED <u>3-19-60</u>
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23a. BURIAL, CREMATION, OR REMOVAL (Specify)	23b. DATE <u>3/21/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Quaking Lem</u>	23d. LOCATION (City, town, or county) (State) <u>Raytown Mo</u>
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24. FUNERAL DIRECTOR <u>Corpe & Sons</u>	ADDRESS <u>192 E. 9th</u>	25. DATE RECD. BY LOCAL REG. <u>3-19-60</u>	26. REGISTRAR'S SIGNATURE <u>Reva Marshall</u>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

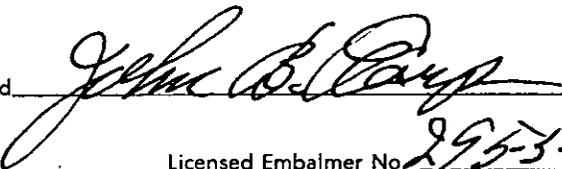
BY AFFIDAVIT OF DWYER

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. 29532

P. O. Address 14. C. 9th

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