

JR DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-010861

FILED VS MAR 28 1960

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1507 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE COUNTY Missouri Jackson	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City	Length of stay in lb 30 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 St. Luke's Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 700 W. 47th St.

3. NAME OF DECEASED (Type or print) First Middle Last Elizabeth L. Clower			4. DATE OF DEATH Month Day Year Mar. 11, 1960		
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5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH July 20, 1890	9. AGE (last birthday) 69	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY Southwest Clinical So.	11. BIRTHPLACE (City and state or country) Independence, Mo.	12. CITIZEN OF WHAT COUNTRY U. S. A.
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13a. FATHER'S NAME William Leas	13b. MOTHER'S MAIDEN NAME Rebecca Cozier	14. NAME OF HUSBAND OR WIFE Joseph W. Clower
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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. 494-12-4550	17. INFORMANT Address Mrs. Louis Loschke, Leawood, Ks.
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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) Cerebro-vascular hem-		INTERVAL BETWEEN ONSET AND DEATH 45 min
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Cerebral arteriosclerosis	4 yr.
	DUE TO (c) Hypertensive vascular disease	15 year
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 checked="" 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
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21. I attended the deceased from **1 Oct 1947** to **11 March 1960** and last saw her ^{her} _{him} alive on **11 March 1960**
Death occurred at **8:10** **P** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>Blaine Z. Hibbard M.D.</i>	22b. ADDRESS 411 Nichols RD KC MO	22c. DATE SIGNED 14 March 60
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23a. METHOD OF CREMATION REMOVAL (Specify) Cremation	23b. DATE 3-14-60	23c. NAME OF CEMETERY OR CREMATORY D. W. Newcomers Sons	23d. LOCATION (City, town, or county) (State) Kansas City, Missouri
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24. FUNERAL DIRECTOR ADDRESS Stine & McClure, Kansas City, Mo.	25. DATE RECD. BY LOCAL REG. 3-14-60	26. REGISTRAR'S SIGNATURE <i>Neva Minshall</i>
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BY AFFIDAVIT OF Blaine Z. Hibbard MEDICAL CERTIFICATION DOCUMENT

JUL 12 1960

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 M. Turner

Licensed Embalmer No. 4648
P. O. Address Kansas City

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.