

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-010924

FILED VS APR 11 1960

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Registration District No. _____ Primary Registration District No. 1002 Registrar's No. 1786 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City	Length of stay in 1b 40 Years	c. CITY OR TOWN Kansas City	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Downtown Hospital		d. STREET ADDRESS (If outside, give location) 4528 Forest	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last Mrs Della Elizabeth Evans			4. DATE OF DEATH Month Day Year March 25, 1960		
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 5-18-96	9. AGE (last birthday) 63 years	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired P.B.X. Opr.		10b. KIND OF BUSINESS OR INDUSTRY Phillips Hotel	11. BIRTHPLACE (City and state or country) Ireland	12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Thomas Ryan		13b. MOTHER'S MAIDEN NAME Mary Duntay DUNLAY		14. NAME OF HUSBAND OR WIFE Bert Evans	
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. 493-22-7527	17. INFORMANT Edmond A. Ryan 4210 Flora Ave.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEPATIC COMA - LIVER FAILURE			INTERVAL BETWEEN ONSET AND DEATH 5 DAYS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE WITH AURICULAR FIBRILLATION		UNKNOWN
	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	Month, Day, Year	Hour 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

21. I attended the deceased from 1-23-1959 to 3-25-1960 and last saw her ~~xxx~~ alive on 3-25-1960
Death occurred at 2:35 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE E. R. C. Thomas MD (Degree or title)	22b. ADDRESS 1222 McGee St., K.C., MO.	22c. DATE SIGNED 3-28-60
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE March 29, 1960	23c. NAME OF CEMETERY OR CREMATORY Calvary
24. FUNERAL DIRECTOR Weillert Funeral Home 6900 Troost Ave.		23d. LOCATION (City, town, or county) Kansas City, Mo. (State)
25. DATE RECD. BY LOCAL REG. 3-28-60		26. REGISTRAR'S SIGNATURE Vera Marshall

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF Robert Negro

DATE: 10/10/74

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 Thomas B. [Signature]

Licensed Embalmer No. 374

P. O. Address AO 7

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.