URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS APR 4 1960

60-010989
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1654

ENDED

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City — Length of stay in 1b: 58 Yrs
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1012 Newton — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Jackson
c. CITY OR TOWN Kansas City — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 1012 Newton — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First DELIA Middle Last HAVINS

4. DATE OF DEATH: Month March Day 19 Year 1960

5. SEX: Female
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 9/23/1876
9. AGE (last birthday): ~~84~~ 83
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): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): Marceline Missouri
12. CITIZEN OF WHAT COUNTRY: USA

13a. FATHER'S NAME: Unknown
13b. MOTHER'S MAIDEN NAME: Hanna Twivy
14. NAME OF HUSBAND OR WIFE: William Havins

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: William Havins Address: 1012 Newton K C Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 mos.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Hypertensive heart disease — 5 yrs.
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. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 11-29-54, to 3-19-60 and last saw her alive on 3-19-60
Death occurred at 1:40 pm on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Wilson H. Miller, M.D. (Degree or title)
22b. ADDRESS 4624 Indep. Ave Kansas City, Mo.
22c. DATE SIGNED 3-21-60

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 3/22/60
23c. NAME OF CEMETERY OR CREMATORY: Green Lawn Cemetery
23d. LOCATION (City, town, or county) (State): Kansas City Missouri

24. FUNERAL DIRECTOR: Sheil Funeral Home ADDRESS: Kanses City Mo
25. DATE RECD. BY LOCAL REG.: 3-21-60
26. REGISTRAR'S SIGNATURE: Neva Minchell

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF Wilson H. Miller

DOCUMENT

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_____ Signed Thomas A. Shiel

Signature of Student Embalmer

Licensed Embalmer No. 495

P. O. Address K.C. Mo.

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

Dr Miller
4608 Indep Ave