

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-011076

FILED VS. APR 11 1968

149

Registration District No. \_\_\_\_\_ Primary Registration District No. 1002 Registrar's No. 1795

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City Mo</u>	Length of stay in 1b <u>40 yrs</u>	c. CITY OR TOWN <u>Kansas City Mo</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>Trinity Lutheran Hosp</u>		d. STREET ADDRESS (If outside, give location) <u>7239 Summit</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Mrs Mabel</u> Middle <u>V.</u> Last <u>Lewis</u>	4. DATE OF DEATH Month <u>3-</u> Day <u>27-</u> Year <u>1960</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7-7-1892</u>	9. AGE (last birthday) <u>67</u>	IF UNDER 1 YEAR Months _____ Days _____	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) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>	11. BIRTHPLACE (City and state or country) <u>Lincoln Nebraska</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>
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13a. FATHER'S NAME <u>Peter Johnson</u>	13b. MOTHER'S MAIDEN NAME <u>Matilda Peterson</u>	14. NAME OF HUSBAND OR WIFE <u>John Ralph Lewis</u>
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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) <u>no</u>	16. SOCIAL SECURITY NO. <u>486-10-1968</u>	17. INFORMANT <u>Betty Gene Ross</u> Address <u>8748 Daniel Boone Rd</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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>arterio-sclerosis</u>		
DUE TO (c) <u>Hypertension</u>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>✓</u>	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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year _____
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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>Kansas City</u>	COUNTY <u>Jackson</u>	STATE <u>Mo</u>
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21. I attended the deceased from January 1959 to March 27-60 and last saw her alive on 3-27-60  
Death occurred at 3-27-60 - 7:00 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>James C. Walker M.D.</u>	22b. ADDRESS <u>1200 Prof Bldg Kcmo</u>	22c. DATE SIGNED <u>3-28-60</u>
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23a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>3-29-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt Mariah</u>	23d. LOCATION (City, town or county) (State) <u>Kansas City Mo</u>
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24. FUNERAL DIRECTOR <u>France-Wornall Funeral Home</u>	ADDRESS <u>K.C. Mo</u>	25. DATE RECD. BY LOCAL REG. <u>3-28-60</u>	26. REGISTRAR'S SIGNATURE <u>Neva Minshall</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JAMES C. WALKER

117

**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 Russell N. France

Licensed Embalmer No. 425

P. O. Address K.C. Mo.

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.