

FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

060-011240

FILED VS MAR 23 1960/49

Registration District No. 1002 Primary Registration District No. 1002 Registrar's No. 1310 STATE FILE NUMBER

UNDECEASED

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</u>		c. CITY OR TOWN <u>Kansas City</u>	
Length of stay in 1b <u>21 months</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>Lindeman Nursing Home</u>		d. STREET ADDRESS (If outside, give location) <u>3933 Harrison</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Gertrude</u> Middle <u>J.</u> Last <u>Sherwood</u>			4. DATE OF DEATH Month <u>3</u> Day <u>3</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>6-14-1883</u>	9. AGE (last birthday) <u>76</u>	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) <u>Homemaker</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>Des Moines Iowa</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>
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13a. FATHER'S NAME <u>John Fanning</u>	13b. MOTHER'S MAIDEN NAME <u>Margaret Grace</u>	14. NAME OF HUSBAND OR WIFE <u>Nelson T. Sherwood</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>349-28-6772B</u>	17. INFORMANT <u>Mrs. G.V. Schuh -- 3933 Harrison</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 <u>7 yrs</u>
IMMEDIATE CAUSE (a) <u>arterio-sclerotic cardiovascular disease</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____ DUE TO (c) <u>advanced age.</u>	

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.)
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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 checked="" 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 <u>Oct 1958</u> to <u>March 1960</u> and last saw her/him alive on <u>March 2-1960</u> Death occurred at <u>2:10 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE (Degree or title) <u>R. Paul Wright M.D.</u>	22b. ADDRESS <u>1324 Prof. Bldg. Kansas City Mo</u>	22c. DATE SIGNED <u>March 4, 1960</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>3-5-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>All Saints Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Des Plaines, Illinois 960</u>
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24. FUNERAL DIRECTOR <u>Melody-McGilley-Eylar</u>	ADDRESS <u>20 W. Linwood K.C. Mo</u>	25. DATE RECD. BY LOCAL REG. <u>3-4-60</u>	26. REGISTRAR'S SIGNATURE <u>Neva Marshall</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

R. Paul Wright

Dr. P.F.
C...
12:30

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 Wm. H. Gentry

Licensed Embalmer No. 5038

P. O. Address K C Mo

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.