

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-011256

FILED VS. MAR. 23, 1960 149

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1312 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 70 yrs		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 4500 Moats Dr.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 4500 Moats Dr.		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle ELLEN Last STEINMETZ				4. DATE OF DEATH Month 3 Day 3 Year 1960				
5. SEX Fem	6. COLOR OR RACE Wh	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 3-3-1889	9. AGE (last birthday) 70	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Floor lady		10b. KIND OF BUSINESS OR INDUSTRY Folgers Coffee		11. BIRTHPLACE (City and state or country) Kansas City, Mo		12. CITIZEN OF WHAT COUNTRY U S A		
13a. FATHER'S NAME John Walter Powers			13b. MOTHER'S MAIDEN NAME Elizabeth Cummings		14. NAME OF HUSBAND OR WIFE John W Steinmetz (Dec)			
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. 486-03-2352		17. INFORMANT Address Agnes Powers, 4500 Moats Dr				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart failure to acute Pulmonary edema DUE TO (b) arterio sclerotic Heart disease DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 2 days 5 years.		
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 Hour _____ Month, Day, Year _____								
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 1955 to 3-3-60 and last saw her/him alive on 3-3-60 Death occurred at 2:00 P m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) Philip J Baker M.D.				22b. ADDRESS 9306 E. New 40 Ind. Tr.		22c. DATE SIGNED 3-3-60		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removed		23b. DATE 3-5-60	23c. NAME OF CEMETERY OR CREMATORY Woodlawn		23d. LOCATION (City, town, or county) Independ, Mo.		(State)	
24. FUNERAL DIRECTOR Sheil J General Home Kc Mo			ADDRESS		25. DATE RECD. BY LOCAL REG. 3-4-60	26. REGISTRAR'S SIGNATURE newa Minshall		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF Philip J. Baker

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 Harold A. [Signature]

Licensed Embalmer No. 499

P. O. Address Kansas City

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.