

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAR 28 1960

60-011298

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1477

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY JACKSON	a. STATE INDIANA	b. COUNTY ST. JOSEPH	
b. CITY (If outside corporate limits, give TOWNSHIP only) KANSAS CITY	Length of stay in lb 6 wk	c. CITY OR TOWN SOUTH BEND	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) ST. LUKES HOSP	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS 833 ASHLAND AVENUE	(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First AGNES	Middle LUCILLE	Last WATERS	4. DATE OF DEATH	Month MARCH	Day 10	Year 1960
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4 9 12	9. AGE (last birthday) 47 yrs.	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) AT HOME	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) NORTH MADISON IND.	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME GEORGE W. WATERS	13b. MOTHER'S MAIDEN NAME NELLIE WRAY	14. NAME OF HUSBAND OR WIFE NONE
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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) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT MRS. E. P. EPLER 3655 MONROE ST.	Address GARY IND.
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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) Asphyxia	72 hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	
DUE TO (b) Atelectasis, pulmonary	72 hours
DUE TO (c) Cor pulmonale	3 years.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Kypho-scoliotic heart disease, chronic	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 SOUTH BEND	COUNTY IND.	STATE
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21. I attended the deceased from 2-26-60 to 3-10-60 and last saw her alive on 3-10-60
Death occurred at 4:20 A. M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Dr. Byers M.D.</i> (Degree or title)	22b. ADDRESS 4635 Wyandotte, Kansas City, Mo.	22c. DATE SIGNED 3-10-60
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23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE MARCH 10, 1960	23c. NAME OF CEMETERY OR CREMATORY SOUTH BEND CEM	23d. LOCATION (City, town, or county) (State) SOUTH BEND IND.
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24. FUNERAL DIRECTOR D. W. NEWCOMER'S SONS KC. MO.	25. DATE RECD. BY LOCAL REG. 3-11-60	26. REGISTRAR'S SIGNATURE <i>Debra Marshall</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF BYERS

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 Albert H. Savage

Licensed Embalmer No. 4812

P. O. Address Newport

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